# PUBLIC HEALTH NURSING



APRIL
1944


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# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## THE 1944 BIENNIAL

IN THIS NUMBER of the Magazine will be found several items concerned with the Biennial Business Meeting of the NOPHN which is to be held June 6, 7 and 8 in Buffalo, New York, in conjunction with the Biennial Meetings of the American Nurses' Association and the National League of Nursing Education.

A brief description of NOPHN sessions and of joint meetings is printed on page 199. Because the Office of Defense Transportation has requested that there be no unnecessary travel this year and also because hotels in Buffalo cannot accommodate a great number of people, NOPHN is not trying to build up a large attendance at its meetings. It does strongly urge, however, that every part of the country, every state organization, and every member agency make sure that it is adequately represented. While there will be no formal program, discussion of matters of great interest and vital importance to public health nursing will occur. Your state, your agency, through its representatives, should have an opportunity to participate in the discussions and help make decisions of far-reaching import.

Suggested revisions of the By-laws appear on page 195. The report of the Eligibility Committee in March PUBLIC HEALTH NURSING explained reasons for the proposed changes in membership classification. These should be re-read and considered with special care.

The slate for officers and members of the Board in the coming biennium will be found on page 188. with a brief biographical sketch of each candidate. Now more than ever before it is important that NOPHN should have a Board that is truly representative not only of various geographical areas, types of public health nursing and administering agencies, but also representative of the whole community it serves. Only so can public health nursing, as in any service essential to the well-being of the population as a whole, be soundly guided in the period immediately ahead when war is still going on but the transition period between war and peace already is beginning. Only so will the NOPHN have the clear vision necessary to plan wisely for the long pull in the reconstruction period to follow.

# A Wartime Public Health Nursing Program

By RUSSELL H. WILSON, M.D., AND LILA ANDERSON, R.N.

THE REMARKABLE increase in the population of the area of the Puget Sound Navy Yard at Bremerton, Washington, has created many public health problems because of a lack of sanitation, school, hospital, housing and recreation facilities.

At the time of the 1940 federal census, the population of the Kitsap County area was 45,000. On July 1, 1943, the population was estimated at 130,000. The Puget Sound Navy Yard has made a continuous effort to bring in additional workers to carry on the much needed war work in this area. This situation is constantly leading to further complicated social and health problems.

The health officer and the staff, realizing in August 1941 the need for utilizing every available public health trained person in the area, took the opportunity to centralize all public health activities of the first-class City of Bremerton and the County of Kitsap. The City of Bremerton had a part-time health officer and two school nurses working separately from the health officer. The County of Kitsap had a part-time health officer doing private practice and three nurses carrying on a specialized school program and some tuberculosis control. This project of unification of public health activities in the area was approached with a great deal of energy and intense interest in order to meet wartime needs. An organization has been perfected within a short space of two years that would have taken several more years during peace time.

In establishing the basic policies and principles of the public health nursing wartime program in the Puget Sound Navy Yard area, we have attempted to eliminate unnecessary activities as indicated in the following two columns.

| The policies, programs and obstacles which we have sought to eliminate or have reduced to a minimum because of the war are: | After giving much thought to the type of activity, we wished to reduce to a minimum or eliminate, we arrived at the following of our goals in the new health department: |
|---|---|
| 1. Decentralized public health nursing supervision and planning | 1. A generalized public health nursing program, including bedside nursing in all instances where it is needed, under central supervision |
| 2. Specialized public health nursing | 2. Assignment of each nurse to a definite district to conduct all nursing activities in a given district |
| 3. Excessive cost of operation | 3. Maximum nursing service to the community at a minimum cost |
| 4. Voluntary nursing programs completely disconnected from the official public health nursing program | 4. All public health nurses are now representatives of the official agency |

| | |
|---|---|
| 5. Disunity of nursing councils and other interested groups in supporting the public health nursing program | 5. Centralized Public Health Nursing Council, and sub-council to consider special problems such as school nursing |
| 6. Disunity of the first-class cities in the County of Kitsap, in that each was attempting to carry on a part-time public health program without endeavoring to cooperate with the other | 6. Unification of all local groups by education and their agreement to render financial support to one centralized public health nursing program |
| 7. Lack of daily planning, emphasis on isolated visits and demonstrations for individuals | 7. Reduction of travel time by planning each day's activities and teaching and demonstrating to groups |
| 8. Visits to a family by more than one nurse | 8. To do communicable disease control, education, bedside nursing, and all other phases of nursing for the family by one nurse |
| 9. Reduction of time spent in the office to an essential minimum | 9. Each nurse was assigned to a definite district |
| | 10. Streamlined record work |
| | 11. Uniformity of monthly reports for all agencies |
| | 12. Time and cost studies are to be made twice annually |

Acting upon this outlined conception of our public health nursing program, the health officer and his staff have interested the local county and city governments in the organization of a district health unit. The district health unit receives its financial support from all organizations official and unofficial that function within the area in the field of public health; namely: American Red Cross, Metropolitan Life Insurance Company, City of Bremerton, County of Kitsap, county and city public schools, State Department of Health, United States Public Health Service, and the Children's Bureau. After all local financial resources had been pooled together with state and federal funds, the American Red Cross was approached with the idea that they might give financial aid to the district health unit. After careful study of the area and evaluation of the possibilities, the Red Cross appropriated funds on an emergency and temporary basis to support additional nurses for the district health unit. This assistance has made it possible for the area health unit to extend the previously limited program to include bedside nursing. Bedside nursing was especially needed because of the extreme lack of medical personnel. Later the Metropolitan Life Insurance Company engaged the nursing services of the Department of Public Health to carry their nursing program. The United States Public Health Service has generously provided the health officer and nursing supervisors.

In the Bremerton area the Puget Sound Navy Yard is the chief industry. The Navy Yard maintains a medical staff for its own industrial health program and sets up its own regulations regarding employment. There is a very close relationship, however, between the Navy Yard Industrial Dispensary and the public health nursing staff, especially in the control of communicable diseases and in the referrals from the Navy Yard Dispensary for follow-up care in the home. Venereal infections and tuberculosis control are two very frequent referrals from the Dispensary since the Dispensary does not treat either of these infections.

Another community agency from which there are frequent referrals is the out-patient department of the Naval Hospital. The Naval Hospital gives medical care to the wives and families of enlisted personnel. Referrals for home nursing are made by the hospital to the public health nursing staff.

In order to further the interest in generalized public health nursing in this area, a centralized Public Health Nursing Council was formed. This Council has representatives from all official and non-official organizations in the community which are interested and could possibly be interested in the visiting nurse service. Groups represented on the Council are: American Red Cross, County Medical Society, County Nursing Society, county and city commissioners, labor unions, schools both county and city, PTA Society, Navy Relief, Metropolitan Life Insurance Company, Bremerton Housing Authority, church groups, USO, County Welfare Department, various rural communities, Orthopedic Guild, and representatives from various hospitals.

The advisory council members meet monthly to approve, discuss and acquaint themselves with the public health nursing program. They return to their organizations and communities within the jurisdictional area to make the services of this nursing group known to their people. Specific subjects discussed are (1) type of service available (2) cost of service to people (3) service available without cost such as to dependents of men in the lower four pay grades of the armed forces (4) publicity (5) procurement of personnel.

In view of the fact that special problems arise with special groups when a completely generalized program is being conducted, we have organized a separate School Nursing Council composed of the public school superintendents in the Kitsap County and Bremerton area. As often as it is necessary, this council meets with the health officer and the director of nurses to discuss the public health nursing problems which are directly related to the schools. The action of the School Council is subsequently acted upon by the centralized Council.

In coordinating all public health nursing groups in the area, it has been possible to make each nurse an official representative of the Health Department. Each nurse is assigned to a district and conducts all activities in her district. There is an advantage in having the nurses representatives of a combined community nursing service because they can assist with venereal disease control, control of communicable diseases, and conduct other official activities of the Health Department in their districts. This eliminates the too frequent situation in which a nurse from a voluntary agency makes a visit which is duplicated by a nurse from an official agency.

The public health nurses can do bedside nursing if needed at the same time that they make a health department visit to a home or vice versa. The nurses in this area are carrying the venereal disease program, tuberculosis program, other communicable disease control, orthopedic, school public health nursing, maternal and child hygiene programs and Metropolitan Life Insurance home nursing.

The nurses are coordinating their activities with the hospitals in order that certain selected hospital patients may return to their homes earlier than they would were hospitalization facilities less overcrowded. The nurses make post-partum visits, render infant care, change surgical dressings, and do any bedside nursing that is necessary. Visits to chronic cases are limited to six except in unusual cases. An acutely ill case may receive as many visits as are necessary.

Patients are permitted to receive one visit before a physician is engaged. All patients must have engaged the service of a physician before further service is

rendered. A charge of $1.25 per visit for the first hour and 50 cents for a second hour is made to all civilian and all Navy personnel except in the lower four pay grades.

The nurses are encouraged to cooperate in a program of continuous staff education and planning in order that they may be informed of the latest developments in the field of public health nursing. The other important benefit of continuous staff education is to formulate plans and policies of a streamlined character in order to meet the demands of the wartime-crowded community.

Each nurse is responsible for the public health education of the people and the general matter of public relations in her district. She meets and acts with various committees, makes instructive talks showing pictures and carrying on demonstrations in her district.

The staff makes constant effort to prepare more complete records, bearing in mind that record keeping should be kept to an effective minimum in order that the time of the nurse may be spent in the field actually carrying on public health or bedside nursing activities. The department has employed full-time clerk-stenographers to assist the nurses in order to eliminate as much time-consuming record and clerical work as possible. The full-time clerk keeps such routine data as the nurses' mileage reports day by day; she makes out the cumulative monthly report from the nurses' daily work sheets.

In view of the fact that there are many agencies supporting the Department of Public Health in Bremerton and Kitsap County, Washington, a large number of reports are necessary for each agency interested in public health nursing in this wartime community. We have streamlined all reports. and have endeavored to make a report form which will be suitable to all concerned. Special reports are made to the American Red Cross and Metropolitan Life Insurance Company.

The Department of Public Health is conducting time and cost studies twice annually. The purpose of these cost studies is to eliminate any unnecessary expenditures of time and money on our part, and to make the program still more efficient in order to meet the very distressing conditions brought about by personnel shortages. We have also employed nurses to do public health work who have not had extensive public health training. This requires very careful planning and supervision in order that the nurse may employ her time as effectively as possible.

The bedside nursing service was organized in conjunction with the American Red Cross, December 1942. However, it did not begin functioning efficiently until July 1943. During the first six-month period of the combined program operation, a total of 7,000 health department and bedside nursing visits were made. Of this total number of calls 1,318, or 18.8 percent, were bedside nursing calls.

Since the inception of this program in September 1941, the following statistics will show what has been accomplished by an average staff of eight nurses in a completely generalized program, each assigned to a definite district of her own and supervised from the centralized official agency, namely, the Department of Public Health, Bremerton-Kitsap County, Washington.

A total of 21,500 home visits were made, September 1, 1941, to September 30, 1943. By type of service these were: Communicable disease, 4,205; venereal disease, 685; tuberculosis, 2,043; maternity—antepartum, 2,319; and postpartum, 1,383; infant, 2,571; preschool, 879; school, 2,810; noncommunicable, 3,789; crippled children, 816.

Other services included 17,652 immunizations; 7,173 clinic visits for treatments; 21,188 school inspections by physician and nurses; 2,516 visits to schools and nursery schools.

# A Unified Service of Long Standing

By EVELYN W. GILCREST, R.N.

FROM the standpoint of administration there are many advantages to a unified program. A single director sees the community as a whole and can plan the nursing service accordingly. There is no overlapping or duplication of effort nor differences of opinion between agencies employing nurses, as to where certain responsibilities begin and end. Obviously there is economy in the use of nursing time, in travel time, in supplies and administrative supervision. Now that the pooling of resources is being stressed so generally, and the streamlining of programs made so necessary by the exigencies of the war, the completely generalized service is more than justifying its widespread trial.

The plan of generalized public health nursing as it is now carried on in Berkeley, California, dates back over 20 years when an amalgamation was effected of all previously existing public health nursing work. It was in July 1923 that Dr. Frank L. Kelly, then assistant professor of public health administration at the University of California, was asked by the superintendent of schools and the city manager to serve as health officer of Berkeley and bring about a combined service.

Since that time the service has grown in scope, developed new services from time to time, but its generalized character has remained the same. In spite of changes of city managers, superintendents of schools, health officers, there has been a steady and continuous development.

In Berkeley the unique part of the service is perhaps the administrative setup. The health officer, responsible to the city manager, is also the director of the school health service and as such is directly responsible to the superintendent of schools. He also serves as medical director of the Berkeley Health and Visiting Nurse Association and in that capacity is responsible to the lay board of directors of that organization. Thus, the director and assistant director of nurses and all staff nurses are directly responsible to the one administrative head.

The financial arrangement differs from many generalized services in that three separate budgets are submitted. Salaries are paid jointly by all three organizations, Health Department, Board of Education, VNA. Car upkeep is paid for by the City and the Visiting Nurse Association. Nursing and field supplies and forms used in each service are paid for by the respective agency for which they are used. Board of Education and Health Department budgets are paid for from tax monies. The Visiting Nurse Association budget, on the other hand, is submitted to the Community Chest which supplements funds received from contracts with insurance companies and industrial plants and fees from patients.

At the present time the staff of the Berkeley Nursing Service, as the combined service is called, consists of the director, assistant director of nurses and 14 staff members, each carrying a district. There is one additional nurse spending full time in the high school and a half-time nurse responsible only for the school work in a junior high school. One additional nurse is employed as a floater to serve as substitute whenever a nurse is ill

and to assist in different parts of the city where the load is heaviest.

Fourteen districts in the city, established as nearly as possible on the elementary school boundary lines, form the basis for nursing districts. Consideration has been given to density of population, economic need and social factors in determining the size of the districts. Four nurses carry two schools; the others only one.

The hours of duty are from 8:30 a.m. to 5 p.m. Usually the nurse spends the first two hours in the school. Those having two schools spend most of the morning in school work, but can arrange to make urgent visits between schools. Calls upon the acutely ill, postpartum visits and visits to the newborn are made in the morning as much as possible. Rather careful screening of the incoming calls in the office is necessary to determine which cases must be seen in the morning and which cases can be visited in the afternoon. The nurse, too, must use good judgment in planning her own work. Physicians, patients and families, and school principals all cooperate with the organization in allowing flexibility in the program which is absolutely necessary to the satisfactory working of such a plan.

The unified program as conducted by the nurses falls into three chief classifications:

*School nursing* provides for the supervision of the health of the school child. Physical examinations are given by part-time physicians and physical inspections by the nurses. Cumulative health records are kept in the schools on all children. Parents' cooperation in the correction of defects is achieved by urging their presence at the examination or through home visits made by the nurses.

The spread of communicable diseases is prevented as much as possible through observation of non-immune contacts, notices of exposures sent to parents, room inspections, and visiting children absent due to illness.

The nurse cooperates with teachers, principals and supervisors in determining the child's physical needs and assisting the school to provide necessary adjustments. Through her knowledge of the home situation and the family health and the importance of these to the child's school progress the nurse makes her main contribution to the school program.

The *health department nursing* program provides for investigation of all communicable diseases, including the supervision of tuberculosis patients and their contacts. The infant welfare program of the health department provides for delivery of certificates of registration of birth to the home, which affords the nurse an excellent opportunity for giving health education. Seven well-baby conferences, open to any child from birth to school age, are conducted by the nurses. A pediatrician examines the child and advises the parent regarding feeding, health habits and immunization. The inspection and supervision of boarding homes for children under 16 years of age which are licensed by the health department is another phase of health department work.

*Visiting nursing* covers visits to acutely ill patients in their homes on a part-time basis. Medical and surgical care and communicable disease nursing is provided. Chronically ill patients are carried only until the family can give adequate care or until other arrangements can be made.

Maternity service provided as a part of visiting nursing includes giving care and instruction to the expectant mother and the necessary care during the post partum and newborn period. Group instruction is given to expectant mothers at the community YWCA.

All visiting nursing visits except those of an advisory or instructive nature only are on a fee basis. Contracts with insurance companies pay the Visiting Nurse Association for visits to policyholders. All other visits where nursing care is given are on a fee basis. The maximum fee is $1.50 for approximately an hour's visit,

with a charge of 75 cents for each additional half hour. Provision is made for adjustment of fee according to the patient's financial situation.

There are many advantages to a service which is completely generalized in this way. From the family's point of view there is the confidence inspired by having one nurse with whom all health problems may be discussed. When the nurse makes a visit because of a physical defect discovered in a school child the mother will ask questions freely concerning her own prenatal care, knowing the nurse will be the one to give her bedside care when she is sent home from the hospital on the fourth day. Continuity of service to the patient and the family is a comfort and satisfaction to a household facing adjustments in health matters. Whatever the original reason for the nurse's visit in the home, she may be called on by the family to counsel and guide and give care for any condition present in the household.

From the standpoint of the nurse the service offers an opportunity for the development of professional knowledge and skill and the satisfaction of using the many approaches the generalized service offers in teaching family health. Many a door reluctantly opened to the health department nurse whose services are associated with "control" is swung wide open when that same nurse calls in response to the private physician's request that she give care to a member of the family who is acutely ill. Since all available information concerning the health of the family is at the nurse's disposal, she has the background for constructive health planning. This enables her to be alert to potential difficulties and use the public health nurse's tools to greatest advantage.

Advantages from the standpoint of administration have already been outlined. The integration of all public health nursing under one administration is fundamentally sound and provides the community with the most efficient service at the lowest possible cost.

## EARLY DIAGNOSIS CAMPAIGN

Since Congress passed the Selective Service Act, about 12 million chest X-rays have been taken at induction stations, resulting in 120,000 deferments for chest conditions. In round numbers, 10 persons are deferred for every 1,000 examined.

During this same period, another 3 million chest X-rays have been taken of apparently healthy industrial workers. More tuberculosis has been found in the civilian group than among men reporting for draft examinations for the apparent reason that a civilian group is made up of persons of both sexes and all ages. About 13 cases of tuberculosis requiring immediate medical care have been uncovered in every 1,000 civilians examined in industrial plants.

For the first time since the fight against tuberculosis was inaugurated, it is possible to estimate the approximate size of the tuberculosis problem and it is much larger than the worst pessimist dared to predict.

Tuberculosis is an infectious disease and unfortunately large numbers of its victims are not aware of their illness until it is well advanced. Long before they know of it, they may be infecting other people and so begins an endless chain of new cases. The chest X-ray helps the doctor find tuberculosis early. The earlier a person's infection is discovered, the greater the promise of his early cure and return to family and work. Through isolation, the spreading of the disease to others is checked.

During April, national, state and local tuberculosis associations together with health departments and physicians are emphasizing the importance of chest X-rays through the Early Diagnosis Campaign. Through the press, over the radio, at meetings, and wherever posters can be placed, people are being urged to have their chests X-rayed. The most important single population group in which tuberculosis can be found by X-ray surveys is the contacts of known cases of the disease as this group yields the largest number of undiagnosed cases per number of persons examined. Consult your health department and nearest tuberculosis association about published materials available for your use in furthering the campaign.

# Management of Skin Problems in Industry

By RUTH G. CANNING, R.N.

FOR OVER a year, following the advice and recommendations of the Connecticut State Department of Health, the management of all skin conditions in employees of the Winchester Repeating Arms Company has been assigned to one nurse, operating under the supervision of the plant physician. It was hoped that by so doing, a more complete and satisfactory control of the dermatoses arising from occupation would be obtained and the opportunity for personal guidance in hygiene and protective clothing and other measures for the employee would be made available. The proposed action was intended to bring about an emphasis on prevention rather than treatment.

The policy of the plant has accordingly been prevention and care of occupational dermatitis in employees. Advice and treatment for minor, non-compensable, skin conditions is given in an attempt to keep the employee on the job, but always with the advice "see your own family doctor if no relief is obtained." Only such bland agents as calomine lotion or boric acid dressings are ever advised for such conditions. When the question of compensability arises the employee is seen either by the plant physician or the consulting dermatologist. No such case is seen more than once by the "skin nurse" without consulting the plant physician.

Individual skin records are kept on all patients with contact dermatitis and all information pertaining to each one is filed for future reference. It has been found satisfactory to include a brief description of the employee's physical characteristics, any possible allergy to causative agents and a brief history of any skin condition or previous treatment he might have received. Information regarding his present job, past experience, and previous contacts is recorded. This card is designed and folded so that it will fit into the unit history folder of the patient's medical record.

Pre-employment examinations prevent the placing of employees with chronic skin conditions on the wrong job. Transfers are given only upon the advice of the dermatologist, as it is believed that many new workers develop more or less of an immunity after being on certain jobs for awhile and are kept at work, while the dermatitis subsides, with proper care.

Protective ointments, prescribed by the dermatologist, are given freely to the employees along with instruction regarding the care of their skin at the end of the day's work. Hand scrub brushes are available and many times the nurse finds it helpful to roll up her own sleeves and show the new worker how a thorough cleansing is done. Hygiene is emphasized to new employees as one of the biggest factors in preventing skin trouble. At the same time they are encouraged to wear the most suitable type of clothing, covering the exposed skin as much as possible, and of equal importance, changing clothing as often as practicable. Rubber gloves, aprons, masks, caps and arm protectors of various types are all available to the employees and they are encouraged to make use of these protective devices. Posting placards around the

plant relating to skin hygiene has also proved effective.

One woman employed on a gauging and inspection job where considerable dirt and dust were present developed a dermatitis on both forearms from the area above her gloves to the elbow where her sleeves ended. It was suggested that she wear a long-sleeved smock, to which she objected because she thought it too warm. The next day, however, she appeared with a pair of men's white socks, with the toes cut off, the edges hemmed. By wearing the heel of the sock at the elbow, adequate protection was provided. These could be easily washed and were inexpensive enough for her to keep several pairs on hand. Most of the workers, if encouraged, will cooperate and help themselves a great deal. A friendly attitude on the part of the nurse is half the battle.

It has been found in caring for simple skin irritations that generally speaking the more mild the treatment, the more effective the cure. If workers are encouraged to report each and every skin irritation as soon as it develops, frequently they are saved lost time and long days of discomfort. A careful check must be made by the nurse to follow each case that is reported to the hospital. Often neglect in keeping accurate records leads to difficulty in determining the exact cause of the disorder, and complications may change the picture.

It is imperative that the skin nurse make frequent visits throughout the plant and watch the employees at work. This enables her to understand the patient's job and his explanation of conditions surrounding it when he comes into the hospital complaining of "brass poisoning" or some non-occupational skin disorder. This also affords an opportunity for the nurse to observe the type of clothing being worn and often a few chosen words during a casual, friendly visit will help the employee to make effective changes. By being thoroughly familiar with all working conditions, the skin nurse is readily able to obtain material for patch tests and turn over all information to the dermatologist. By working as a team—doctor, nurse and employee—greater efficiency results and the incidence of occupational skin disorders is minimized.

# Statement of Company Policies Governing the Health Program

IN KEEPING with our established policy of maintaining the highest possible standards of employer-employee relationships, and to make available to our employees such services and assistance as are consistent with good business management, we recently inaugurated a comprehensive health program, improved our hospital facilities, and provided expert nursing, medical and surgical service for our personnel.

Over a period of many years, we have demonstrated that the industrial nurse is in a particularly strategic position to counsel with and advise our employees in matters pertaining to general health and personal hygiene. Because of her training and sex, and the fact that she is not directly associated with the production organization, many employees, when visiting the hospital, take the opportunity to unburden themselves of real and imaginary grievances or troubles not necessarily connected with their work or the company. Sympathetic understanding

This company directive was provided by G. Virginia Prann, factory nurse, National Folding Box Company, New Haven, Connecticut.

and friendly advice have often proved mutually helpful. Many of the discussions between employee and nurse are of a confidential nature and are so regarded. In some instances, she may learn of conditions which need correction and can obtain action without specifically divulging the source of her information, when by so doing it might cause embarrassment to the employee. The personnel work in which the nurse engages helps to develop a mutual bond of confidence between nurse and employee. When employees realize that they have a friend in the hospital looking out for their interests much of their reluctance to visit it disappears, as does their frequent fear of surgical treatment.

Close contact by the nurse with employees and department heads sometimes reveals the need for home visits and she is the logical individual to perform this service as a representative of the company, building good will and imparting constructive advice where possible.

It is only natural that the nurse should be health and accident conscious and she is, therefore, particularly qualified for membership on the safety committee. While she may not be mechanically-minded, and has only a limited knowledge of machine processes and equipment, she is more likely to observe any unhealthful working conditions that may exist, unsafe practices, and minor accident hazards. This work again brings her in close contact with employees and she has the opportunity to observe in a friendly way individuals at work. When injured or sick employees report to the hospital for advice or treatment, these particular activities of the nurse are invaluable to her and to the company.

We recognize, of course, that an industrial nurse is not permitted by law to prescribe, practice medicine, or treat cases unless under the supervision and direction of a doctor. A competent doctor and one or more qualified alternates direct the medical and surgical activities of our hospital. We realize that the question of medical ethics enters into this procedure; nevertheless it is reasonable to expect that in his direction of the hospital the doctor will take into consideration the fact that the company requires exceptional experience, training and capabilities in a nurse, and that recognizing these qualities he will permit her all possible latitude in the dispensing of ordinary drugs as well as in the treatment of minor injuries.

The nurse, through her close association with the company family and because she lives with them, talks with them and listens to their troubles, is naturally closer to the individual than it is possible for the doctor to be. The doctor, however, can gradually obtain the confidence of employees by availing himself of the wealth of information which the nurse has and letting her act as an intermediary. If the nurse is not permitted to remove splinters or take care of minor bruises, abrasions and strains, the employee naturally concludes that she is incompetent. Unfavorable employee reaction is bound to result, injuries will be reported reluctantly and the mutual confidence that is so necessary to the success of the health program will be lost. However, it is imperative that the doctor be called immediately where the nature of an injury is such as to require his attention. Where specialized treatment is indicated, the nurse will, as a matter of course, refer the employee directly to an ophthalmologist, orthopedist, dermatologist, or such other specialist as the case may require.

We regard the doctor as our medical adviser and in this capacity he makes available to our employees such medical advice as is consistent with medical ethics without charge to the employee. It is, however, important that the Personnel Department review all such cases before authorizing the nurse to request the doctor to see them, as it is a privilege that could be easily abused and cause many complications if not properly controlled. We

believe that it is consistent with medical standards for the doctor to instruct the nurse in technique and permit her to handle minor accident cases as well as to establish the procedure to be followed in what we might term borderline cases. We realize that some errors of judgment and differences of opinion are bound to occur in cases which are not readily definable, but if a common understanding between doctor and nurse can be reached as to just what constitutes a borderline case, no confusion should result.

The doctor is an essential member of our organization and is in a position to render invaluable service both to our supervisory staff and employees. We have no thought of relegating the doctor to a secondary position. In fact, it is important that he command the respect and confidence of our entire plant personnel. In time he will become just as familiar with our people and their problems as we are, but during a transition period natural resistance on the part of the employees to hospital procedure must be largely overcome by our Personnel Department and nurse. Every effort must be made to prevent department heads and employees from losing confidence in our nurse and hospital; otherwise we know from experience that many injuries will not be reported. If the doctor understands that the reluctance of many employees to see the doctor is due to the feeling that their injuries must be of a serious nature to warrant such attention, and that lost time and subsequent lost pay is likely to follow, he will better appreciate the value of the nurse to him in his contact with the employee. It is this employer-employee relationship that places the industrial hospital in an entirely different category from a doctor's office, regular hospital or operating room. Failure to recognize this inherent difference will unquestionably result in unfavorable employee reaction.

It must be thoroughly understood that the hospital and all its activities are definitely a part of and are under the direction of our Personnel Department. The nurse, being in constant daily attendance and subject to call 24 hours a day, is the natural source of routine information. It is her responsibility to keep the Personnel Department informed through daily reports as to the conditions under which each accident occurs, the progress of cases, treatments given and lost time. It is important that all department heads be informed promptly of all accidents so that proper investigations may be made and corrective action taken where indicated. It is further suggested that a conference be held weekly between the personnel manager, doctor and nurse so that the activities of the hospital may be discussed. When the doctor makes his daily call it would be helpful if he would review with the nurse the hospital activities for the previous day, and if in his judgment he considers certain cases to be potentially dangerous, unusual or questionable, he would personally examine the employees concerned. However, in order that the Personnel Department may be kept fully informed, the doctor should immediately report the circumstances and results of such special examinations to the Personnel Department on the form provided for this purpose.

In order that there may be no misunderstanding with regard to the requirements or policies, it might be well to have a conference with the doctor and nurse and obtain their reaction to this procedure. It is important that all parties be in agreement and that there be full cooperation between all concerned if our program is to function smoothly.

# The Patient Referral System

By BERNADINE C. KRAUS, R.N.

IN SPITE of the worries that come with an accelerated nursing program and the shortage of staff nurses, we find that if the faculty and staff believe in a thing enough, they are able not only to carry it on, but to tackle new duties in order to improve the quality of service to the patient and to make more vital the learning situations of the student nurse.

That is what has been happening at the Syracuse (New York) Memorial Hospital School of Nursing in the last year. A loyal faculty and eager staff nurses have cooperated in a program which actually meant additional work for them but which they felt was worth the time and effort required.

Integration of the positive and preventive, the social factors of nursing, is generally accepted as being an essential part of the curriculum of every school of nursing. How the integration takes place differs in every school, but there are certain basic principles which must not be overlooked.

The first is that, like health itself, awareness of the patient as an individual, consideration of the social factors of a situation, and understanding and teaching of positive and preventive health cannot be taught by textbook or lecture. It must be lived, acted, practiced. The very setup of the hospital itself, therefore, must be that of a cooperating community agency, a place where those from whom the students are learning are practicing health conservation in the broadest sense.

The second principle follows naturally from the first and emphasizes the importance of the *staff* in carrying out any program of integration. Most of the workers in this field agree that staff education is basic to integration and they have worked out excellent programs for this purpose.

I do not wish to go into the usual techniques of staff education since they have been described and are no doubt already in use in most hospitals. However, it was after analyzing the staff education program and the practices of the hospital itself that those responsible for the program at Memorial Hospital felt a need the answer to which finally developed into what I will describe as the "Patient Referral System."

Syracuse Memorial Hospital is a 270-bed general hospital. The nursing staff consists of thirty-four full-time graduate nurses, twenty-one part-time graduate nurses, and eighty-six students. We have three resident physicians, eight interns, and one medical social worker. The students of the Syracuse University Medical College have experience in the hospital in the obstetric, pediatric and gynecologic services.

In Memorial, as in most hospitals, the Social Service Department with the Admitting Office is the connecting link between the hospital and outside agencies and, in cooperation with the physician, handles all discharge plans for the patients.

In analyzing this situation we found that the general staff nurses actually had no part in planning for the patient's care after discharge from the hospital, even though they were very often the ones most closely connected with both the patient

and his relatives. The discharge needs of the patients were considered only in a very general way, and what happened to the patient after he was referred to the Social Service Department was rarely known to the nurse. It did not concern her much and, for that reason, she learned nothing about it.

We found that, while in some instances teaching of patients was done by physicians and nurses, this practice was not consistent nor was it done on all the wards.

It took no genius to see that one medical social worker could not possibly consider the needs and plan for every patient who left the hospital. Yet, in order that the hospital might perform its function as an agency for the conservation of health as well as the care of the sick, no patient should be discharged without a consideration of where he is going, what situation he is going into, and what care he will receive when he gets there.

We wished to give the nurses responsibility in carrying out continuity of medical and nursing care and the job was there to be done if we could set up a plan that would be consistent, automatic, and would clear through Social Service.

As an answer to this, the "Patient Referral Form" was developed by the family health advisor, a public health nurse responsible for the integration of public health in the curriculum, as the basis of the patient referral system.

### The Patient Referral Form

The form is, in short, a device whereby the nurse on the ward is given the responsibility of planning for her patients in an area which had formerly been that of the medical social worker but an area which is strictly limited to the field in which the nurse has had her training, namely, nursing care and the interpretation of medical orders. It cannot be emphasized too strongly that the nurse, while being aware of the social and emotional factors of illness, should not try to diagnose or treat or plan for patients in whom these factors are involved. These functions are still in the sphere of the social worker and should be referred to and discussed with her.

Because the patient referral form goes through the hands of the social worker, it gives her as many assistants as there are staff nurses doing the planning for their patients, and the logical channel of referral of patients from the ward nurse and physician to the public health nurse or outpatient personnel is established.

Needless to say, a system such as this which involved administrative procedure in the hospital required much ground work before it could go into operation. The family health advisor first met individually with those most closely concerned: the hospital superintendent, the medical social worker, the admitting officer, and the director of nurses, and having secured their consent to try the system, proceeded to present the plan to others involved in its use.

The form with the tentative objectives of the system and plans for its use was then presented to a committee consisting of the chief of the Pediatric Service, the resident in pediatrics, the nursing supervisor and assistant in pediatrics, the director of nurses, the educational director of the School of Nursing, and the medical social worker. The agenda for this meeting consisted of discussions of these questions:

1. Should we give such a form a trial period? (If we agree to try the form, then—?)
2. What details need to be added to the form omitted, or changed?
3. When can we meet with representatives of the health agencies concerned?
4. What suggestions are there concerning the tentative plans for continued use of the form?

It was agreed to try the plan for three months and plans were made for another meeting at which details could be worked out.

Later that same month a meeting was held which was attended by representatives of the agencies that would be receiv-

ing the form: the directors of the Visiting Nurse Association and the Bureau of Nursing, the supervising nurse of the District, State Health Department, the medical social worker of the County Department of Public Welfare, the supervisors of the Pediatric Service, the director of nursing service of the hospital, and the medical social worker of the hospital. All outside agency representatives agreed that they would like to see the form used.

The plan was then presented to the staff nurses on the Pediatric Service and they agreed to give it a trial. At the end of the three-months' trial period, the committee again met to decide whether or not its use should be continued. When the question was asked of the group, it soon was evident that the system had stood the test and it was unanimously decided to continue to use it on the Pediatric Service with the other services being added as we became more familiar with the system.

The objectives as finally accepted were as follows:

1. To refer patients for nursing care and supervision in the home.
2. To notify the Department of Public Welfare and the Veteran's Relief of discharge, diagnosis, and medical orders of patients for whom they are responsible.
3. To notify the Syracuse Free Dispensary of medical diagnosis, treatment given, and orders on the patients referred by them.
4. To notify other hospital personnel of diagnosis, treatment, and orders in case of transfer.
5. To give the public health nurses the information they need in order to give the patient intelligent care with purposeful teaching.
6. To establish a method of referring patients in time to make that referral of value.
7. To ensure that the physician's instructions concerning care after the patient's discharge from the hospital have been explained to the patient and recorded.
8. To provide a check list for the head nurse so that she may see that the things which influence the continuity of medical and nursing care have been done.
9. To guide the referral of patients through one channel, the Social Service Department.
10. To provide a written record for future reference or study of what has been done about arranging for follow-up care and instructions to patients.

It was necessary to set up the following regulations in order to administer the system:

1. A Referral Form is made out by the head nurse on all ward patients whether or not they are referred to an outside agency.
2. A Referral Form is made out on any private patient for whom the physician requests public health nursing care or supervision.
3. A physician signs the form when medical orders are part of the referral.

## How the Referral System Works

A description of how the system works is given in the following example:

Jane E., four years of age, is admitted to the hospital with a diagnosis of malnutrition and possible bronchial pneumonia. The admitting officer sends to the floor, along with the admission slip, a patient referral form. The head nurse puts it on the child's chart. During the time the patient is in the hospital, the Visiting Nurse Association calls to inquire about the child whom they had been instrumental in admitting to the hospital. The head nurse, knowing that this is valuable information in regard to the referral of the patient for nursing care, places a check on the form in the box "Known to VNA."

When the child has been in the hospital ten days, the physician says that the patient's condition will warrant discharge providing someone can continue giving the insulin which the child has been getting to help improve appetite. The head nurse has the physician write the orders which he wishes carried out in the home; she tells him that the child is already known to the Visiting Nurse Association and that they will be asked to go into the home on the following day to see that discharge orders are carried out if he wishes. He does.

Having discussed this child's problems with the medical social worker, the head nurse knows that because of a broken home and lack of finances the child will go to the home of an aunt.

When the aunt comes in the next day,

the head nurse observes that she is an interested, teachable young woman. She discusses with her the care which the child will need to have, emphasizing diet and rest. She shows the aunt the equipment necessary for giving insulin and explains the details of administering it. Realizing, however, that the administration of insulin is a complicated procedure, she suggests that she arrange for a public health nurse to come into the home the next day to help her with the procedure for a few times. She instructs the aunt to take Jane to the Syracuse Free Dispensary in a week and makes an appointment for this visit.

Before the patient is discharged, the nurse puts the aunt's address on the form under "address" or "location of home." She knows how important the correct address is to the public health nurse.

She puts the following facts on the form before sending it down to the admitting office with the discharge slip:

1. *Summary of treatment while in the hospital.* Bed rest, vitamins and insulin for appetite. (Note: We are planning to make this more complete to include the results of diagnostic tests and X-rays, also therapy administered, so that it will be more useful to the dispensary physician and medical personnel in other hospitals in case of transfer.)
2. *What medical supervision is the patient going to be under?* (The dispensary, date, and time of appointment is put on the form.)
3. *Medical orders on discharge.* (This has already been written on the form by the physician.)
4. *What instructions were given the patient or parent?* (Instructions as to care to be given and the administration of insulin are written in here.)
5. *What nursing supervision is needed?* (The nurse checks "Health Agency," supervision in administering insulin.)
6. *Is the patient expecting a nurse to call?* (Yes, and the date of expected first visit is written in.)
7. *Does the patient know how to carry out the physician's orders in a manner that will be safe and that will give maximum desired results?* (She needs supervision for a time.)

The head nurse signs the form and it goes to the admitting office where financial data is checked. In this case the County Department of Public Welfare is paying the bill.

The form is taken immediately to the Social Service Department office where the medical social worker considers the plans in the light of her knowledge of the family and records information for her records: date of referral, agency referred to, and reason for referral. On the back of the form she adds social data which will be useful to the public health nurse or any other professional worker receiving the form.

In this case, the original form with orders signed by the physician was sent by mail to the Visiting Nurse Association and copies went to the Syracuse Free Dispensary, to the Department of Public Welfare, and a copy was filed with the patient's record.

That's the way it works. Needless to say the quality of the teaching done and the final form which comes to us depends on the interest and knowledge of the individual nurse. Much credit goes to the ward supervisor, her assistant, and the head nurses in the Pediatric Department who kept the ball rolling in spite of handicaps.

## The Student Nurse Program

Syracuse Memorial students do not affiliate for public health nursing experience. Graduate public health nurses have priority to the field experience available and rightly so. However, the nurses on the staffs of the public health agencies gladly take the students on observation visits into their patients' homes.

It is a simple matter to use the patient referral system in a student program for the student, under the guidance of the ward supervisor, instructs the patient or parent, finds out the needs and fills out the form. A small slip attached to the patient referral form notifies the public health nurse receiving it that a student

would like to visit with her in this home. The public health nurse calls the ward supervisor making plans for the student to accompany her.

When a visit is planned, the student fills out a supplementary discharge form with additional information which is not put on the patient referral form; she contacts the medical social worker and discusses the case with her; then makes the visit in the home with the public health nurse. She writes up her visit, has a conference with the public health nurse, and, in some cases, presents for discussion an interpretative study to the other members of the class in pediatric nursing and representatives of the agencies concerned.

We have used the form now for one year on the pediatric wards. Because we believe it has been successful there, we are planning to use it throughout the hospital in the near future.

What do the people using the form think about it? I quote a ward nurse.

> In a way we resent having it inferred that we need a form to make us aware of the needs of our patients, and we find filling it out time-consuming, but we do find it helps us remember the things we should consider about the patient and understand more about the agencies concerned.

The director of the Visiting Nurse Association says:

> The form gives us what we need to know in order to give intelligent nursing service to the patient in the home. It is material we have to take time to either write or phone for, thus disturbing the physician or hospital nurse and taking our time from the field. The form assists us in cutting down the valuable time consumed in the office which should be given to the care of patients.
>
> The program has been of great assistance to the patients in securing continuity of nursing service. The visiting nurse acts as a connecting link between the attending physician and the patient in the home, seeing that his orders are carried out. She also sees that whatever future medical supervision he suggests is carried out and thus assists in preventing the patient from becoming a repeater in the hospital because of lack of nursing care, medications, or medical assistance.
>
> The program gives the student nurse some idea of what public health nursing is like because she spends three half days in the field observing the different types of services rendered by the visiting nurse. Two graduate students from the Department of Public Health Nursing of Syracuse University, with us for their field affiliation, frankly say that their interest in public health nursing was first aroused through the referral program.

A pediatrician who has participated in our program says:

> All hospitals should have a method of referring patients for follow-up care, especially the children who have had infectious diseases.

We expect there will be many details to be worked out in the next year as we continue to use the form on the other wards in the hospital, but we believe that basically it is sound and that it does answer a very deeply felt need in the hospital and in the community which the hospital serves.

# Selecting the Nurse for Industry

**This statement, prepared by the Executive Committee of the Industrial Nursing Section of the NOPHN, is intended as a temporary guide to management in the selection of a nurse and not a description of minimum qualifications**

INDUSTRY NEEDS the open-minded, competent nurse who is not afraid of work, obstacles or people and this is a field where both men and women who meet professional requirements have equal opportunity for broad usefulness. The professional preparation beyond graduation from an accredited school of nursing and registration in the state of employment depends on the position in the industrial health service for, just as in the hospital or public health organization, there is a range in positions from junior staff nurse to head of the department. The nurse recently graduated from a school of nursing can give useful service in any industry where she is working under direct and competent nursing supervision. It is recognized that the inexperienced nurse is not prepared to develop a health service where none previously existed nor to carry responsibility for a department where she is the only full-time health worker.

Industrial medical practice is not solely the treatment of occupational disabilities. A sizeable financial stake is involved in absenteeism due to non-occupational illness, as well as in workmen's compensation and—directly or indirectly—the employer, the employee, and the community all pay their share of this cost. Accident prevention and health education have long been stressed and industrial medical practice is looking toward a post-war expansion of service in which keeping the worker well will have main emphasis.

Because industrial nursing is a specialized branch of nursing, it is recommended that a nurse entering the field of industry have additional preparation after graduation from an accredited school of nursing. This preparation is being made available in many universities offering courses in public health nursing especially to prepare nurses who wish to enter the industrial field.

The nurse needs to have a working knowledge of industrial hygiene, workmen's compensation, accident prevention and safety promotion, plant sanitation, industrial welfare activities and personnel administration, nutrition, communicable disease control and mental hygiene. She needs to be acquainted with community health policies and resources, public health and industrial hygiene organizations—local, state, federal and national.

Experience in the field of generalized nursing is valuable. Practical knowledge, such as that gained by working in an out-patient department, for instance, or within a visiting nurse service or health department, is an asset. For the newly-appointed industrial nurse, the planned period of orientation in her own plant should include the opportunity to visit other well-established industrial health services. Whether her program provides service to the employee in the plant only or is extended to him in his home, the nurse's ability to use and cooperate with

community health organizations is of inestimable value to the employer and employee.

Certain personal qualifications contribute to the effectiveness of the nurse in industry. These include the ability to work with people and to contribute toward good working relationships, professional dignity, emotional stability, tolerance, initiative, skill in teaching, and the ability to act wisely in an emergency. For the nurse working alone, foresight, ability to organize her service, and resourcefulness are also essential. The supervising nurse must have qualities of leadership, executive ability, special aptitude for teaching, and vision as to the potentialities of the service.

As in other professional fields, nurses in industry will be interested in maintaining membership in their local, state and national nursing organizations in order to keep their own professional standards high and to contribute to the sound development of professional nursing.

Often the nurse is the only full-time health worker in an industrial service; the scope of her work is broad and the results of her decisions have far-reaching implications in compensation costs and in employee relations. In a competitive system where the cost of accidents and illness is inevitably added to the cost of production, the health service is an asset or it is a liability added to a liability. Therefore, thorough preparation for her work is the responsibility of the nurse. Discriminating selection of the nurse for the position is the responsibility of management.*

*The following will be helpful in securing qualified industrial nursing personnel: Nurse Placement Service, 8 South Michigan Boulevard, Chicago 3, Illinois; local professional nurses' registries; directors of public health nursing courses in universities and colleges; state industrial nursing consultants in state departments of health.

## NURSE PLACEMENT SERVICE

NPS announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

### PLACEMENTS

*Marcetta Horne, generalized supervisor, State Department of Health, Cass-Sarpy-Otoe Health Unit, Bellevue, Neb.

*Bessie Leiby, supervisor, Visiting Nurse Association, Coatesville, Pa.

Mrs. Alice Maclin, teacher of health and hygiene, Gary Public Schools, Gary, Ind.

*Melida Ouellette Thompson, assisting health teacher in schools, Bronx Tuberculosis and Health Committee, Bronx, N.Y.

Margaret Wishard, case finding nurse in industry and schools, New York Tuberculosis and Health Association, New York, N.Y.

Mrs. Desdemona Mattison, staff nurse, Infant Welfare Society, Oak Park, Ill.

Orida Olds, staff nurse, City Health Department, Elmwood Park, Ill.

*Mable Stitt, industrial nurse, Tuttle and Kift, Inc., Chicago, Ill.

Mrs. Marjorie Wallin, industrial nurse, Aetna Ball Bearing Company, Chicago, Ill.

Mrs. Eleanor Lynn, industrial nurse, Hannisin Manufacturing Company, Chicago, Ill.

Mrs. Marjorie Evatt, industrial nurse, American Brake Shoe Company, Ramapo Ajax Division, Chicago, Ill.

*Mrs. Helen Davis, industrial nurse, Standard Transformer Company, Chicago, Ill.

### ASSISTED PLACEMENTS

*Mrs. Elizabeth Martin, director of nursing activities, American Red Cross, Southeastern Pennsylvania, Philadelphia, Pa.

*Ruth Laxton, assistant to director of nursing, American Red Cross, Southeastern Area, Atlanta, Ga.

*Josephine Keough, staff nurse, Henry Street Visiting Nurse Service, New York, N.Y.

*Maybelle Bielefeld, visiting nurse, Metropolitan Nursing Service, Harvey, Ill.

Mrs. Hildur Egan, staff nurse, Chicago Department of Health, Chicago, Ill.

*The NOPHN files show that this nurse is a member.

# Summer Courses for Public Health Nurses

## SUMMER COURSES IN UNIVERSITIES WHOSE PROGRAMS OF STUDY IN PUBLIC HEALTH NURSING HAVE BEEN APPROVED BY THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

**California**

**Berkeley. University of California.** June 26-July 14. Institute on Community Control of Venereal Disease (3 units). Nursing and social problems in the control of syphilis and gonorrhea; Medical problems in the control of syphilis and gonorrhea.

For further information write to Margaret Tracy, Director, School of Nursing, Zone 4.

**Los Angeles. University of California.** June 26-August 4. Courses in community needs and resources, with coordinated workshop of American Red Cross Chapter activities, principles and practice of public health nursing, public health and preventive medicine, administration of the school health program. June 26-July 14. Institute on hearing conservation with workshop for teachers and nurses; Youth Problem Institute. July 26-August 4. Community control of syphilis and gonorrhea.

For further information write to Dr. J. Harold Williams, Director of Summer Sessions, 405 Hilgard Avenue, Zone 24.

**Colorado**

**Boulder. University of Colorado.** June 29-August 24. Courses in public health administration, advanced public hygiene, nutrition and dietetics. Intersession, August 26-October 21. Courses in teaching nursing and health, principles of sociology, general psychology.

For further information write to Mrs. Pearl Parvin Coulter, Associate Professor of Public Health Nursing.

**District of Columbia**

**Washington. The Catholic University of America.** Third term, June 12-September 23. Courses in public health nursing, public health nursing in adult health supervision, methods of learning health, public health administration, psychobiology, social conditions and problems. Summer session, June 30-August 12. Courses in supervision in public health nursing, public health nursing in maternal and child health, public health nursing in school health programs.

For further information write to Janet F. Walker, Director, Division of Public Health Nursing, School of Nursing Education.

**Illinois**

**Chicago. Loyola University.** First session, June 26-August 4. Courses in principles and organization of public health nursing, public health administration, social work for public health nurses, principles of health teaching, social problems relating to public health, industrial nursing, orientation in public health nursing. Second session, August 7-September 2. Courses in school health problems, nutrition. Courses in English, education, biology and philosophy leading to the B.S. in public health nursing are also available.

For further information write to Edna Lewis, Director, Department of Public Health Nursing, 28 N. Franklin Street, Zone 6.

**Chicago. The University of Chicago.** First session, June 19-July 8; Second session, July 10-September 9. Courses in principles of public health nursing, special fields in public health nursing, supervision in public health nursing, teaching of health, field work, organization and administration in public health nursing.

For further information write to Nellie X. Hawkinson, Professor of Nursing Education, Zone 37.

# SUMMER COURSES

**Indiana**

**Bloomington. Indiana University.** First session, April 27-June 23. Courses in principles of public health nursing, maternal and child care, field work, nutrition, social case work, and other allied fields will be offered. Second session, June 24-August 21. Courses in principles of public health nursing, principles and methods of teaching, field work, and allied courses will be offered.

For further information write to Frances Orgain, Assistant Professor in Nursing Education, School of Education.

**Massachusetts**

**Boston. Simmons College.** June 26-August 4. Courses in principles of teaching, nutrition for nurses, principles of public health nursing, public health nursing in schools.

For further information write to the Director, School of Nursing, The Fenway, Zone 15.

**Minnesota**

**Minneapolis. University of Minnesota.** First session, June 14-July 22. Courses in public and personal health, health of the school child, mental hygiene, principles of public health nursing, field practice in rural nursing, field practice with family health agency, preventive medicine, public health administration, environmental sanitation, topics in public health, workshop in industrial health. Second session, July 24-August 26. Courses in elements of preventive medicine and public health, tuberculosis and its control, field practice in school nursing, field practice in rural nursing, field practice with family health agency, special methods and supervised teaching in health education for public health nurses, nutrition for public health nurses, public health administration and field work, conservation of hearing, workshop in community and school health education. A special sequence of courses has been arranged for the supervisor—First session, courses in supervision in public health nursing, supervision laboratory, principles and problems of teaching social hygiene, principles and practices in health education, principles of social case work, problems in public health nursing; Second session, courses in vital statistics, personality development in education, parent education, problems in public health nursing, principles and problems of teaching social hygiene, guidance in secondary schools.

For further information write to Ruth B. Freeman, Director, Course in Public Health Nursing, 121 Millard Hall.

**Missouri**

**St. Louis. St. Louis University.** First session, May 15-June 17. Courses in special phases of public health nursing, organization and administration of public health nursing. Institute, May 15-June 10. Public health nursing in venereal disease. Second session, June 19-July 29. Courses in methods of teaching home nursing, principles of public health nursing, principles of teaching applied to public health nursing.

For further information write to A. Louise Kinney, Director, Division of Public Health Nursing, School of Nursing, 1325 South Grand, Zone 4.

**New Jersey**

**Newark. Seton Hall College.** First session, July 3-July 21. Courses in principles of public health nursing, dental health education, school nursing; courses in psychology, sociology, education, and science. Second session, July 24-August 11. Courses in special fields in public health nursing, methods in teaching home nursing, child growth and development, courses in psychology, sociology, education, and science. Third session, August 14-September 1. Courses in mental hygiene, practical speech training.

For further information write to the School of Nursing Education, 72 Central Avenue, Zone 2.

**New York**

**Brooklyn. St. John's University.** Intersession, May 31-June 30. Courses in educational psychology, child psychology, industrial nursing. Summer session, July 5-August 15. Courses in general psychology, sociology, biology, public health nursing principles and special fields. Guest instructor, Heide L. Henriksen, industrial nursing.

For further information write Mary C. Mulvany, Acting Director, School of Nursing Education, Teachers College, 96 Schermerhorn Street, Zone 2.

**Buffalo. The University of Buffalo.** July 5-August 12. Courses in introduction to case work for nurses, principles of school nursing, principles of public health nursing II (special fields), the guidance program in schools of nursing, history of nursing and current trends; also courses in sociology, general psychology, child psychology, the family, educational psychology, etc.
For further information write to the School of Nursing, 25 Niagara Square, Zone 2.

**New York. Columbia University, Teachers College.** May 29-June 9. Materials and methods in head nurse education (workshop). July 3-August 11. Courses in principles and methods of teaching, foundations of nursing education, the modern school of nursing and its educational program, evaluation and reconstruction of nursing procedures, materials and methods of instruction for the first course in nursing arts, guided study for students in nursing education, organization and administration in nursing schools, student observation and teaching in nursing subjects, management of the hospital nursing unit, educational activities of the hospital nursing unit, field work in nursing, anatomy and physiology, elementary microbiology, teaching of home nursing, public health nursing, school nursing, supervision in public health nursing, preventable diseases, personnel administration and guidance in nursing (July 17 to 28).
For further information write to Division of Nursing Education, Zone 27.

**New York. New York University.** Intersession, June 6-30. Courses in the administration of public health, workshop in nursing arts, field work courses in public health nursing for the four-month period beginning June 1; field work courses in hospital nursing for the three-month period beginning June 1. Also courses in microbiology, mental hygiene, psychology, and sociology. First summer session, July 5-21. Courses in community problems and the nurse, problems in nursing education, principles of public health nursing I, principles and methods of teaching in nursing education. Ward management, clinical teaching, industrial nursing; also courses in biology, psychology, and social case work. Second summer session, July 24-August 11. Courses in problems in nursing education, teaching activities of the public health nurse, introduction to supervision in public health nursing, advanced clinical teaching, pharmacology, and therapeutics, supervision of school attendance; also courses in organization of school nursing I, assisting the family with wartime adjustments, nutrition, biology, and psychology. Postsession, August 14-September 8. Courses in principles and methods of teaching in nursing education, introduction to nursing education. Courses at Lake Sebago, July 3-August 11. A special group of courses will be offered to meet the needs of nurses who are interested in the rehabilitation of the physically disabled through the adaptation of recreational activities. These include: physiological aspects of recreational therapy, physical inspection, foundations of a philosophy for American recreation.
For further information write to Dr. Helen C. Manzer, Associate Professor of Education, School of Education, Washington Square East.

**Syracuse. University of Syracuse.** July 3-August 12. Courses in public health and public health nursing, the role of the nurse in public health services, nursing in schools, preventable diseases, case work methods in public health nursing, methods of learning health applied to public health nursing, ward teaching, industrial nursing. The ward teaching will be a three weeks' course and industrial nursing two weeks' course, both beginning July 3. Courses will also be offered in nutrition, sociology, education, and psychology.
For further information write to Ruth TeLinde, Acting Director, Department of Public Health Nursing, College of Medicine, Zone 10.

**Ohio**

**Cleveland. Western Reserve University.** June 19-July 28, July 31-September 8. Courses in public health nursing, principles of public health, principles and methods of teaching in nursing, curriculum in schools of nursing, ward management and teaching; workshop on administrative problems of accelerated programs, directed by Helen M. Bunge, June 12-16.
For further information write to Marion G. Howell, Dean, School of Nursing, 2063 Adelbert Road, Zone 6.

**Oregon**

**Portland. University of Oregon.** July 3-September 15. Courses in principles and organization in public health nursing, field work in public health nursing, community organization, intro-

duction to case work methods, mental hygiene, systems in public health nursing, methods in teaching. Intersession Institute, June 19-July 1. Course in mental hygiene.

For further information write to Maisie V. Wetzel, Acting Assistant Director, Public Health Nursing, Department of Nursing Education, Zone 1.

**Pennsylvania**

**Pittsburgh. Duquesne University.** Pre-summer session, June 12-June 30. Courses in public health nursing III, (maternal and infant health programs). Regular summer session. Public health nursing IV (school nursing), teaching in public health nursing.

For further information write to Catherine M. McDermott, Director, Public Health Nursing, Zone 19.

**Pittsburgh. The University of Pittsburgh.** June 26-July 21. School nursing. Six weeks' summer session, June 26-August 4.

For further information write to the University Registrar or to Dr. Dorothy Rood, chairman, Department of Public Health Nursing, 2820 Cathedral of Learning, Zone 13.

**Tennessee**

**Nashville. George Peabody College for Teachers.** June 12-August 25. Courses in principles and organization of public health nursing, maternal, infant and preschool health, communicable disease, school nursing, sanitation, public health administration, health and nutrition, industrial nursing, supervision in public health nursing, administration in public health nursing, community health education.

For further information write to Aurelia B. Potts, Director, Division of Nursing Education, Zone 4.

**Nashville. Vanderbilt University.** June 12-August 19. Course in public health nursing. Institute; May 22-June 3. Workshop on administrative problems in nursing service and nursing education.

For further information write to Office of the Dean, School of Nursing.

**Texas**

**San Antonio. Incarnate Word College.** First session, June 5-July 4; second session, July 16-August 25. Courses in introduction to public health nursing, public health administration, maternal and child health, social case work, supervision in public health nursing, methods of teaching health; field experience at Austin-Travis Health Unit.

For further information write to Alice Marcella Fay, Director of Program of Study in Public Health Nursing.

**Washington**

**Seattle. University of Washington.** July 3-August 28; July 3-October 21. Courses in special fields in public health nursing, social case work, methods of hospital supervision, principles of teaching health, epidemiology, methods of supervision in public health nursing. In addition courses in sociology, education, psychology, English composition and public speaking will be offered. A two weeks' course in psychiatry and psychiatric nursing is also being planned; the date will be announced later.

For further information write to Elizabeth S. Soule, Director, School of Nursing Education.

**Wisconsin**

**Milwaukee. Marquette University.** July-October. Courses in principles of public health nursing II, maternal and child hygiene.

For further information write to Susan Purtell, Director, Public Health Nursing, College of Nursing, 3058 N. 51 Street, Zone 10.

# Standing Orders, 1943

By DOROTHY E. WIESNER AND MARGARET M. MURPHY

IT IS HIGHLY important that public health nursing practices be consistent with the medical consensus of the community, and for this reason it is suggested that each county medical society approve certain policies involving nursing procedures and instruction, for the guidance of public health nurses." This is recommended practice as stated in the *Manual of Public Health Nursing*.* Standing orders for health education, prevention of communicable disease, morbidity service, maternity service, and for the nurse in the school and in industry are discussed in the manual.

Because of war changes in communities, particularly because of shortage of physicians, inquiry was made concerning recent changes in standing orders in the 1943 NOPHN Yearly Review. Replies from 584 agencies were classified under five types—municipal health departments, county health departments, boards of education, nonofficial agencies, and combination agencies. It was found that 80 percent of the total had standing orders, ranging from 68 percent in boards of education to 94 percent in nonofficial agencies. Fifty-five percent had either adopted or revised their standing orders after January 1, 1940, ranging from 36 percent in municipal health departments to 65 percent among the nonofficial agencies.

*Endorsement of standing orders.* In the Manual is the sentence, "Standing orders are endorsed by the medical advisory committee of the agency, the local medical society, and the local department." Answers to the question in the Yearly Review, "By whom were standing orders approved?" showed that state and county medical societies were the endorsing agents in many instances. Among 220 nonofficial agencies with standing orders, 112 mentioned medical advisory committees. In 84 instances this committee was the sole approving agent, and in the others it served in combination with medical societies, health departments, nursing committees, or boards of directors. Among 66 municipal health departments, the local health officer was most frequently mentioned as the endorsing agent, 21 times; in 13 instances the state or county medical societies were named. The 66 county health departments, however, mentioned state and county medical societies 31 times; state and county health departments 16 times. Among the 94 boards of education, 28 mentioned the board itself, and 25 mentioned school superintendents; only 13 mentioned state or local medical societies. The 22 combination agencies named county medical societies 11 times, and their medical advisory committees 6 times.

*Extent of changes.* With this background of the status of standing orders, replies to the question, "Are you contemplating a change in these orders because of a shortage of medical personnel?" have more meaning. Of the 468 agencies with standing orders 27 percent reported that they had changed them, or were planning

*National Organization for Public Health Nursing. Manual of Public Health Nursing. The Macmillan Company, New York, 3rd edition 1939, p. 140.

to change them because of shortages of physicians—nonofficial agencies, 38 percent; municipal health departments, 23 percent; county health departments, 18 percent; boards of education, 11 percent; combination agencies, 36 percent. The greater proportion of changes among the nonofficial and combination agencies is apparently due to the bedside care programs of these agencies.

*Kinds of changes.* The kinds of changes made do not threaten traditional relationships. They may seem trivial to those not aware of such traditions. Allowing two visits instead of one for a patient not seen by the physician; accepting telephoned physicians' orders for an individual case; changing from maternity and infant welfare clinics (with physician in charge) to nurse conferences; adding nurse hours to clinics to save physician-hours; starting maternity classes for wives of military men; assisting at draft board examinations; adding vaccination to the nurse's duties; adding the changing of feeding formulas and infant diet to her duties—these are some of the ways standing orders have been changed to adjust to fewer physician hours. By the time this material is in print, doubtless more agencies and probably more methods of spreading medical and nursing care will have come into the picture.

*Visits to patients under care of practitioners other than M.D's.* Because inquiries have been coming to headquarters as to how nursing agencies are responding to call from practitioners other than doctors of medicine, data were gathered about service of this type. Among the 584 agencies, 39 percent reported they cared for patients referred only by M.D.'s, and 20 percent did not answer the question. Health departments frequently reported that they would visit patients referred by anyone licensed by the state to practice, and would follow up any reported case of communicable disease, including those reported by lay persons. Health departments also mentioned midwives among those whose calls were answered. Osteopaths were most frequently mentioned as non-M.D. practitioners whose patients were served, 31 percent of the 584 agencies naming them, and 50 percent of the 235 nonofficial agencies. Only 9 nonofficial agencies mentioned chiropractors in this connection. Boards of education reported frequently that since the nurses gave no continued treatments, and since in many instances the problem had never arisen, they could not reply very completely.

Among practitioners other than those mentioned above, dentists, podiatrists, optometrists, physicians practicing without licenses, and naturopaths, the latter only for communicable disease cases, were named as persons whose patients might be referred for nursing care.

*Summary.* These data were collected in the spring of 1943. They show that 27 percent of the agencies with standing orders had either changed their standing orders or were planning to change them because of shortage of physicians. Changes were more frequently reported by agencies with bedside care programs. Accepting the physician's verbal instead of written order, visiting more often than formerly before the physician sees the patient, and the substitution of nursing conferences for physicians' clinics were more frequently mentioned.

## INDUSTRIAL NURSES IN ANNUAL SESSION

**The American Association of Industrial Nurses will hold their annual convention at the Hotel Jefferson, St. Louis, Missouri, May 12, 13, 14, 1944. This important branch of nursing with over 1,600 members has planned a program for this meeting expressive of its varieties of industries, and accompanying problems. Catherine Dempsey of Boston is president of the Association.**

# Undergraduate's Progress

## AN EIGHT-WEEKS' AFFILIATION WITH THE SAN FRANCISCO VISITING NURSE ASSOCIATION

DEAR DIARY:

The first week of my visiting nurse affiliation was indeed a different experience for me. One of the rather surprising events was that the patients assumed I was a graduate registered nurse.

I have learned that visiting nursing really needs independent thinking and mature judgment. There is no head nurse in the home to whom to run. It appears there are many problems a nurse can help a patient meet—problems that seem difficult for a patient or family in time of sickness.

This was the first time that I had taken money for the nursing care I had given. To think that my bathing this little old lady has been worth money to her broadened my outlook on nursing as a career.

* * * *

As I glance over the second week's work, and compare it with the first, I am struck by the acceptance of the nurse in the homes. She becomes a part of the family—to be expected and looked for on certain days, a friend of the family group.

The qualms passing through our new nurse's head, no one could ever imagine unless experiencing them herself. As she rides along in the streetcar she wishes it would hurry and get there sooner, and yet she rather wishes it would never reach its destination. Each trip is an adventure. She never knows what environmental situation she may find nor what personalities she will meet.

Tuesday there was the family with all the trials and tribulations of having the mother bedfast, two small children, a working husband, and being unable to get help for the patient or household. Then there was the young boy who suffers from arthritis, who grins constantly while his mother bustles about entertaining friends as the nurse searches frantically for clean pajamas and gives FGC, now known as "Full General Care." Of course I cannot forget the little Englishman who was found on Friday lying on the floor where he spent the night after collapsing. He twinkled his eyes as he looked up at the visiting nurse and two firemen who finally replaced him in bed, and said, "I'll call out the marines next time!"

Although of minor importance to the patient's care, yet of great satisfaction to the nurse by the second week of her work, is the appreciation of her efforts by the patients. One elderly gentleman pats her hand and says modestly, "You know, I like you." Another stands at the door taking up five minutes of the nurse's valuable time explaining to her the "quickest route downtown." Another patient insists that she take "a paper bag full of walnuts from the tree in the back yard" and she must carry these all day on the streetcar and in and out of homes.

And so the blue uniforms with conservative felt hats and walking shoes continue on their way.

* * * *

Thinking over the third week, I find myself wondering how much money patent medicines cleared this week on my patients. I don't think I had a single call

where I failed to hear, or observe the results, of some remedy accepted through newspaper or radio advertising. One patient suffering from days of diarrhea and vomiting took a dose of this laxative and a tablet of that alkaline powder—one to "clean out the bowels" and the other to "sweeten an acid stomach." Another patient confided that most people over 50 should take a daily dose of a certain concoction which is "a mild regulator fitted to meet the needs of aging intestinal muscles."

Patients can recite word for word the advertisement of their current pet remedy and are as firm as Gibraltar in their conviction of its value. When an old-fashioned dose of salts is replaced by a fancy patent constipation remedy, and baking soda gives way to vitamin D toothpaste, you can imagine how loud and fast some radio announcer has been talking. The nurse is at a disadvantage because she must compete with intriguing phrases murmured soothingly or blasted warningly over the radio every 15 minutes to exhort the numerous virtues of some product.

I have been more than busy this week working on a food budget, and I have discovered it isn't as easy as it sounds. Of course this difficulty was aided and abetted by today's high prices about which I do not know too much. I know that there are price ceilings, but I did not realize that that ceiling was so very high and that everyone hit the ceiling.

It was fun, however, and certainly educational to contact a patient and work up a plan for the family. Now that the budget has been made I really feel that I did learn a few of the trials of housewives and cooks. No matter how large or small the group, it takes planning to order and prepare the proper amounts of essential foods and to see that each member of the family has an adequate diet.

* * * *

Oh, Diary, the baby business has been booming lately, or so it would seem from the increased number of maternity calls and infant health supervision visits I have made during my fourth week.

R-r-r-ring, r-ring sounds the doorbell. No one answers. Another push at the button but no answer. Maybe the door is unlatched? Just as the nurse puts her hand on the knob that horrible buzzing sound starts—but at least she has received a response. As she opens the door and looks up the dark stairway she catches a glimpse of small figures leaning their heads over the top railing. As usual her greeting is met by a sudden disappearance of the bobbing heads and a call is heard, "Mama, mama, a lady's here."

The nurse feels her way up the dark, curved stairs and along the long hall to the combination living and bedroom. A tiny tired mother lying on the bed in her housecoat smiles at the nurse and says, "You must be the nurse they said would come out to bathe the baby today."

After some minutes of delay the nurse may be successful in finding the newspapers or in gaining the confidence of one of the older children who brings her several sheets. Upon asking where the baby toilet tray is kept, the nurse is met with a barrage of excuses.

Finally the nurse has everything ready and picks the baby out of the buggy. The mother is seated comfortably where she can watch. "Now we start by washing the baby's face with this soft cloth and no soap. We do not unwrap him yet, because . . . ." The telephone rings, mother looks at nurse apologetically and arises to answer it. It seems that Aunt Hazel just called to see how the new baby was faring. In the meantime the nurse wonders whether she should continue with the demonstration without an audience or play with the baby until the mother returns. She decides in favor of the latter, and soon the mother is seated again.

The bath continues; the mother grows more interested. The nurse is emphasizing the daily washing of the scalp and the method for doing this when a loud wail from the backyard distracts the mother.

Now she runs to the window to settle a disagreement between four-year-old Junior and the neighbor boy. Just as the baby is undressed, and the nurse has impressed the mother with the necessity of not chilling him, the neighbor lady drops in to see how the baby and mother are feeling. She stands holding the back door open while she relays the news that the children downstairs have the whooping cough.

Finally the nurse finishes the baby's bath, with the once quiet infant now screaming loudly. "Thank goodness, the mother is going to breast-feed the baby," thinks the nurse as she discards the newspapers into the stove.

The nurse leaves a quiet and peaceful household. The baby has been fed and is back in his bed and the mother has agreed to rest until time to prepare lunch for the older children.

* * * *

Now there is the matter of the cooperation of the various agencies of the community for the benefit of the patients. Time was when I was unalterably optimistic about this matter. Then came a day early this fifth week when I learned that agency cooperation might prove otherwise. But again later in the week my optimism was in part restored.

Some ten days ago the —— Department had arranged with one of the clinics to supply the drugs for a patient's care. The Department would give the medical supervision and the VNA the nursing supervision. When the day came for the patient to go for the new drugs the clinic refused them on the basis of wanting to give either full care or nothing. After numerous calls to the clinic, the Department, and my own office, final orders were received for the visiting nurse to call once a week and the patient to receive medical care as planned by the relief agency. I was dumbfounded to learn that agencies would allow such a thing as possessive favoritism to interfere so seriously with a patient's progress.

But then later in the week came a delightful instance of helpful cooperation. It was in the care of the same patient. Miss T., our diabetic patient, customarily makes the rounds of three churches every Sunday morning before attending to either insulin or breakfast. Her aim is to take communion weekly. I thought perhaps one of the priests of her favorite church could help out.

So at 11:30 on Saturday morning I was greeted by Father W. at —— Church. Bits of gravy and other unknown materials were visible on the front of his long brown robe. The interview room was austere and very quiet. But I had no more than stated the problem of Miss T. before in rapid, business-like speech he agreed to make a personal call on her and set her right on the exact nature of her obligations. Then with a "thank you for your consideration for her religious needs," he bade me goodbye.

* * * *

Time certainly flies. Our sixth week of visiting nurse affiliation has passed. It hardly seems possible it has been that long since I rang that first doorbell. I have had an unusually large number of contacts with doctors this week. It amazes me how the phrase "this is the visiting nurse" opens so many gates. At first the secretary is inclined to be reluctant about calling him to the phone but as soon as those magic words are uttered she is all cordiality and in a few seconds the doctor himself is on the phone. The doctors are more than willing to supply the needed information and never fail to finish with, "Thank you very much for calling."

* * * *

Dear Diary: Finally the time has arrived when I must return my bag, and take off the blue tie which marks me as one of the VNA nurses. The time has sped by, and it seems like only yesterday when I stood before the mirror one morning futilely trying to tilt the navy blue felt at a more attractive angle! It's strange, too, how attached one becomes to

that black leather bag—but what tales it could relate if it took the notion. That bag is a faithful friend. In fact, I can almost believe that the leathery surface looks shiny black in the morning when I set out and dull brown when my tired feet trudge home at night. Farewell, faithful little bag!

Diary, to you may I be so sincere as to say regarding visiting nurse affiliation simply, "It's the best yet!" I wonder if the attraction is the "spirit of adventure" due to working so closely with human relations. There is an inexplainable fascination about working in people's homes, their confidence in the nurse, and the opportunities for teaching and helping people, which does not seem to be duplicated in any sort of nursing service I have yet attempted—even though in many instances the nurse may not secure the ends for which she strives. She must have an ideal. And yet a strain of the materialistic and practical must be a part of her blood. She must be sympathetic and able to imagine herself in the place of any member of the household in order to decide her approach to problems. Some of the specific problems I have touched upon during past weeks, Diary, but I believe a nurse who has not had some home nursing experience is much more apt to have less understanding of her patients, and be blinded to the fact that the patient is a part of some sort of household to which he must return, and where adjustments may have to be made.

Needless to say, I am very happy I was allowed the privilege of affiliation with the VNA. Also my heartiest gratitude goes to those kind souls who struggled along with me to acquaint me with the routines and with the possibilities in visiting nursing. And for all those suggestions and corrections—thanks to the supervisors, and staff members!

I regret that my San Francisco Visiting Nurse Association experience has ended.

Good health and long life,

"JUST ME"

## FOR ELECTION AT BIENNIAL

The Nominating Committee presents the following list of candidates for officers and directors of the National Organization for Public Health Nursing for the biennial period 1944-1946. The suggestions sent in are embodied in the ballot which is presented here. Space is left for you to vote (by writing in the name) for another candidate than the one presented, if you so desire, when you receive your official ballot. The official ballots and instructions for voting will be mailed to all members before May 1. The method of "voting by proxy" as adopted by the membership at Chicago, Illinois, 1942, is a change in terminology and formal procedure in compliance with the law. It does not alter the ability of members to vote by mail.

OLIVIA T. PETERSON, CHAIRMAN
HELEN F. DUNN
JEAN G. ROBERTS
KATHARINE TUCKER
ANNE R. WINSLOW

# NOPHN Ballot

PRESIDENT AND DIRECTOR*

☐ Marion W. Sheahan, R.N., Albany, N.Y. ☐ .....

FIRST VICE-PRESIDENT AND DIRECTOR*

☐ Emilie G. Sargent, R.N., Detroit, Mich. ☐ .....

SECOND VICE-PRESIDENT AND DIRECTOR*

☐ Mrs. David K. Ford, Cleveland, Ohio ☐ .....

TREASURER AND DIRECTOR*

☐ W. Lawrence McLane, New York, N.Y. ☐ .....

SECRETARY AND DIRECTOR*

☐ Ruth Houlton, R.N., New York, N.Y. ☐ .....

DIRECTORS—NURSE MEMBERS**

Vote for five

☐ Gladyce L. Badger, R.N., San Francisco Calif. ☐ .....
☐ Mary Beard, R.N., Washington, D.C. ☐ .....
☐ Mrs. Mary H. Emberton, R.N., Denver, Colo. ☐ .....
☐ Pauline E. Kuehler, R.N., Whiting, Ind. ☐ .....
☐ Mrs. Dorothy Chamberlin Lowman, R.N., Salt Lake City, Utah ☐ .....
☐ Ella E. McNeil, R.N., Ann Arbor, Mich ☐ .....
☐ A. Mary Ross, R.N., Kansas City, Mo ☐ .....
☐ Julia Dupuy Smith, R.N., Richmond, Va. ☐ .....
☐ Dorris Weber, R.N., New Haven, Conn ☐ .....
☐ Alberta B. Wilson, R.N., Dover, Del. ☐ .....

DIRECTORS—NON-NURSE MEMBERS**

Vote for eight

(Two at least must be chosen from those whose names are in italics, representing board or committee members of public health nursing services or organizations)

☐ Jessie M. Bierman, M.D., San Francisco, Calif. ☐ .....
☐ *Mrs. Charles S. Brown, New York, N Y.* ☐ .....
☐ Edwin F. Daily, M.D., Washington, D.C. ☐ .....
☐ Albert W. Dent, New Orleans, La. ☐ .....
☐ *Mrs. Walter G. Farr, Brookside, N.J.* ☐ .....
☐ Hugh R. Leavell, M.D., Louisville, Ky. ☐ .....
☐ Mrs. Walter Lippmann, Washington, D.C. ☐ .....
☐ Joseph W. Mountin, M.D., Washington, D.C. ☐ .....
☐ *Mrs. Stuart W. Rider, Minneapolis, Minn.* ☐ .....
☐ Rose Schneiderman, New York, N.Y. ☐ .....
☐ Nathan Sinai, Dr.P.H., Ann Arbor, Mich. ☐ .....
☐ *Mrs. Sumner Spaulding, Beverly Hills, Calif.* ☐ .....
☐ *Mrs. Langdon T. Thaxter, Portland, Me.* ☐ .....

NOMINATING COMMITTEE 1944-1946

Vote for five

☐ Zella Bryant, R.N., Washington, D.C.
☐ Eula B. Butzerin, R.N., Washington, D.C.
☐ Mrs. F. S. Dellenbaugh, Litchfield, Conn.
☐ Laura A. Draper, R.N., Minneapolis, Minn.
☐ Amy Louise Fisher, R.N., Raleigh, N.C
☐ Anna C. Gring, R.N., Montclair, N.J.
☐ Marie Neuschaefer, R.N., Des Moines, Iowa
☐ Lucile Perozzi, R.N., Washington, D.C.
☐ Rosalie I. Peterson, R.N., New York, N.Y.
☐ Mrs. S. Emlen Stokes, Moorestown, N.J.

*For 2-year terms.
**For 4-year terms

# Who's Who on the NOPHN Ballot

**Officers**

*President:*

Marion W. Sheahan—Albany, N.Y.

Graduate, St. Peter's Hospital, Albany, N.Y. *Positions held:* private nursing; child welfare nurse, Cohoes, N.Y.; Henry Street Settlement, New York City; city nurse, Bureau of Health, Albany, N.Y.; county nurse, Niagara County, N.Y.; supervising nurse of tuberculosis, New York State Department of Health; assistant director, Division of Public Health Nursing, New York State Department of Health. *Past affiliations:* chairman, Section on Public Health Nursing, and nurse representative, Committee on Administrative Practice, American Public Health Association; board member, New York State Nurses' Association. *Present affiliations:* member, Advisory Committee to the director of the Nursing Service, American Red Cross, and member, Advisory Council; member, Committee on Public Health, Procurement and Assignment Service, War Manpower Commission; first vice-president, NOPHN, 1940-44; chairman, Subcommittee on Nursing, New York State Health Preparedness Commission; member, New York State Nursing Council for War Service; member, Advisory Council to Board of Regents, New York State Department of Education. *Present position:* director, Division of Public Health Nursing, New York State Department of Health.

*First Vice-President:*

Emilie G. Sargent—Detroit, Mich.

Graduate, Mount Sinai School of Nursing, New York City; B.A., M.S., University of Michigan. *Positions held:* field nurse and assistant director, Visiting Nurse Association, Detroit, Mich. *Past affiliations:* president, Detroit District Nurses' Association; president, treasurer and vice-president, Michigan State Nurses' Association; board member, American Nurses' Association; president, Michigan Public Health Association. *Present affiliations:* board member, Michigan Public Health Association; chairman, Michigan Nursing Council for War Service; chairman, Group Health Insurance Committee, Michigan SNA; board member and chairman, National Membership Committee, NOPHN; member, National Committee on Group Health Insurance; member, Executive Committee of the Study Committee of Voluntary Agencies, National Health Council; member, Nursing Advisory Committee, Metropolitan Life Insurance Company; chairman, Advisory Council to Department of Nursing, Wayne University; member, Executive Committee, Detroit Health Council; other local offices and committee memberships. *Present position:* executive director, Visiting Nurse Association of Detroit.

*Second Vice-President:*

Elizabeth Brooks Ford (Mrs. David K.)—Shaker Heights, Cleveland, Ohio

*Offices held:* president, Visiting Nurse Association of Cleveland; chairman, Advisory Committee, University Public Health Nursing District, Cleveland; trustee, The Welfare Federation of Cleveland; board member, Cleveland Health Council; board member, The Maternal Health Association of Ohio; volunteer nurses' aide, University Hospitals, Cleveland.

*Treasurer:*

W. Lawrence McLane—New York, N.Y.

St. George's School, Middletown, R.I.; Cornell University; Graduate School of Banking, Rutgers University; trustee, Roosevelt Hospital, N.Y.C.; director, Hotel Wayne; Skidmore Coal Company; member, Central Finance Committee, United Hospital Fund of New York; member, Board of Managers, Seamen's Church Institute of New York; Big Brother Movement; member, Veterans' Association of the 107th Infantry; member, Society of Mayflower Descendants; member, St. Andrews Society of State of N.Y.; member, Board of Trustees, Norwalk General Hospital, Norwalk, Conn.; associated with J. P. Stevens and Company, Inc., New York, N.Y.; treasurer, NOPHN, for the last biennial period.

*Secretary:*

Ruth Houlton—New York, N.Y.

Graduate, University of Minnesota, Ancker Hospital, St. Paul, Minn.; postgraduate course in pediatrics and nursing, Child's Hospital, New York, N.Y. *Positions held:* special Red Cross nurse in army hospital and with the Tuberculosis Commission in Italy; nursing field representative with the American Red Cross in Minnesota; superintendent of nurses, Child Hygiene Division, Minnesota State Department of Health; executive director, Visiting Nurse Association, Minneapolis; assistant director, then associate director of the NOPHN. *Present position:* general director of the NOPHN.

**Directors—Nurse Members**

Gladyce L. Badger—San Francisco, Calif.

Graduate, Highland Hospital, Rochester, N.Y.; B.S., University of Michigan, Ann Arbor. *Positions held:* county public health nurse, Washington County, Ind.; nursing consultant, Northwest Territory, American Red Cross; nursing consultant, New York and New Jersey, ARC; director of nursing service, Pacific area, ARC. *Present affiliations:* member, California State Nursing Council for War Service; member, Committee on Domestic Postwar Planning, National Nursing Council for War Service; member, California State Supply and Distribution Committee; member, California State Student Nurse Recruitment Committee; member, Governor Warren's Citizens' Committee on Student Nurse Recruitment. *Present position:* director, Nursing Service, ARC, Pacific Area.

Mary Beard—Washington, D.C.

Graduate, New York Hospital School of Nursing, New York, N.Y.; Doctor of Humanities, honorary degree from University of New Hampshire. *Positions held:* chief nurse, Waterbury Visiting Nurse Association, Waterbury, Conn.; director, Instructive District Nurses' Association, Boston, Mass.; director, Community Health Association, Boston; associate director, International Health Division, Rockefeller Foundation, New York, N.Y. *Past affiliations:* president, NOPHN. *Present affiliations:* board member, American Nurses' Association; board member, National Nursing Council for War Service. *Present position:* director, Nursing Service, American Red Cross, Washington, D.C.

Mrs. Mary H. Emberton—Denver, Colo.

Graduate, Miami Valley Hospital, Dayton, Ohio; postgraduate study in public health nursing and B.S. degree, Teachers College, Columbia University, New York, N.Y. *Positions held:* staff nurse and supervisor, Denver VNA; nurse in health education demonstration, Denver Tuberculosis Society; advisory nurse, Maternal and Child Health, State of Colorado Division of Public Health; director, Child Welfare and Community Health Association, New Orleans, La. *Past affiliations:* chairman, Public Health Section, Colorado State Nurses' Association, also board member; board member, Colorado Public Health Association; president, Colorado State Nurses' Association. *Present affiliations:* board member, Colorado Public Health Association; president, Colorado State Nurses' Association. *Present position:* director, Division of Public Health Nursing, State of Colorado Division of Public Health.

Pauline E. Kuehler—Whiting, Ind.

Graduate, Presbyterian Hospital, Chicago; special courses, Universities of Chicago and Indiana; two years, Parsons College, Fairfield, Iowa. *Past affiliations:* chairman, Industrial Nurses' Section, Indiana State Nurses' Association; member, Committee to Study the Duties of Nurses in Industry. *Present affiliations:* chairman, Membership Committee, American Association of Industrial Nurses; chairman, Industrial Nurses' Section, National Safety Council; president, Industrial Nurses' Organization, N.W. District, Ind.; services on local nursing council and procurement and assignment committee. *Positions held:* staff nurse, The Visiting Nurse Association of Chicago. *Present position:* industrial nurse, Standard Oil Company (Indiana) Hospital, Whiting, Ind.

Mrs. Dorothy Chamberlin Lowman—Salt Lake City, Utah

Graduate, Dr. W. H. Groves Latter-Day Saints Hospital, Salt Lake City; B.S. at University of Oregon; postgraduate work in public health nursing at University of Oregon Medical School, Portland, Ore. *Past affiliations:* secretary and president, Utah State Organization for Public Health Nursing; vice-president, Utah State League of Nursing Education; board member, Utah State Nurses Association, District I; treasurer, Oregon State Organization for Public Health Nursing. *Present affiliations:* board member, Utah State Nurses Association; treasurer, Utah Public Health Association. *Positions held:* nursing supervisor, Salt Lake City and County Boards of Health; assistant supervisor, Portland City Board of Health; county public health nurse, Summit County, Utah; Jordan district school nurse, Salt Lake County, Utah. *Present position:* director, Division of Public Health Nursing, Utah State Dept. of Health.

Ella E. McNeil—Ann Arbor, Mich.

Graduate, University of Michigan and University Hospital School of Nursing; A.M. from Teachers College, Columbia University, New York. *Past affiliations:* vice-president, Pennsylvania SOPHN; vice-president, Michigan SOPHN; vice-president, State Nurses Association, Michigan; board member, Board of Registration for Nurses, Michigan. *Present affiliations:* chairman, NOPHN Committee on Counseling and Placement; member, ANA Committee on Counseling and Placement; president, State Nurses Association, Michigan. *Positions held:* staff public health nurse; assistant director, Bureau of Public Health Nursing, Indiana Department of Health; director, Public Health Nursing S.E. Pennsylvania Chapter, American Red Cross; assistant director, NOPHN. *Present position:* associate professor of Public Health Nursing, University of Michigan.

A. Mary Ross—Kansas City, Mo.

Graduate, Children's Mercy Hospital, Kansas

City, Mo. Postgraduate work at University of Minnesota. *Past affiliations:* vice-president and board member, Second District, Missouri State Nurses Association; health chairman, Central District Health and Physical Education; chairman, Kansas City Public Health Nursing Committee. *Present affiliations:* member, Kansas City Nursing Council for War Service; member, Kansas City Procurement and Assignment Committee; state chairman, State Public Health Nursing Section; board member of League of Hard of Hearing, Social Hygiene Society, Council of Social Agencies, Personnel Practices Council, and Children's Milk and Health Committee; chairman, Kansas City Health Council. *Positions held:* "follow-up" nurse, Children's Mercy Hospital; nurses supervisor, Missouri State Tuberculosis Sanatorium, Mt. Vernon; school nurse, Kansas City; supervisor, Special Schools. *Present position:* supervisor of nurses, Public Schools, Kansas City.

Julia Dupuy Smith—Richmond, Va.

Graduate, University of Pennsylvania School for Nurses; B.A., Hollins College; M.A. from Teachers College, Columbia University, N.Y. *Present affiliations:* board member, District V, Graduate Nurse Association, Richmond; member, Recruitment Committee, American Red Cross, Richmond Chapter; member, Education Committee, NOPHN; member, Nursing Council for War Service, Richmond; member, Coordinating Committee, Public Health Nursing Program of Study, Medical College of Virginia. *Positions held:* school nurse, Finch Junior College, New York, N.Y.; psychiatric nursing, New York, N.Y.; staff nurse, Rutherford County Health Department, Tenn.; educational director and assistant director, Instructive Visiting Nurse Association, Richmond. *Present position:* director, Instructive Visiting Nurse Association, Richmond.

Dorris Weber—New Haven, Conn.

Graduate, Washington University School of Nursing, St. Louis, Mo.; M.A. from Teachers College, Columbia University, New York. *Past affiliations:* member, Board of Administrative Officers, Washington University School of Nursing, St. Louis, Missouri; chairman, Public Health Nursing Section, and board member, Connecticut State Nurses Association; chairman, State Membership and Revision Committee, Connecticut SNA. *Present affiliations:* chairman, Legislative Committee, Connecticut SNA; chairman, Cost Analyses Committee, NOPHN. *Positions held:* staff nurse and supervisor, East Harlem Nursing and Health Service, New York, N.Y.; educational director, Visiting Nurse Association, St. Louis, Mo. *Present position:* educational director, Visiting Nurse Association, New Haven, Conn.; assistant clinical professor, Yale University School of Nursing.

Alberta B. Wilson—Dover, Del.

Graduate, Beebe Hospital of Lewes, Inc., Lewes, Delaware; B.S. from Temple University, Philadelphia, and M.S. from University of Pennsylvania. *Present affiliations:* volunteer Red Cross instructor and member of State Committee, in Home Nursing and Nurse's Aide; member, Cost Analyses Committee, NOPHN; chairman, Delaware State Nursing Council for War Service; president, Delaware State League of Nursing Education; board member, Delaware Chapter, American Red Cross; State Nurse Deputy, OCD; member, State Procurement and Assignment Committee. *Positions held:* staff nurse and assistant supervisor, VNA, Wilmington, Delaware; school nurse, Madison Public Schools, Madison, New Jersey; assistant supervisor, Eastern Health District, Baltimore, Md.; instructor, Public Health Nursing, Pennsylvania Hospital, Philadelphia, Pa.; supervisor, Community Health and Civic Association, Ardmore, Pa. *Present position:* director, Division of Public Health Nursing, Delaware State Board of Health, Dover.

**Directors—Non-Nurse Members**

Jessie M. Bierman—San Francisco, Calif.

Graduate of the University of Montana, M.D. from Rush Medical College, University of Chicago. *Present affiliations:* member, American Medical Association; member, American Public Health Association; member, American Academy of Pediatrics. *Past positions:* practicing pediatrician, San Francisco, Calif.; instructor in pediatrics, University of California Medical School; director, Division of Child Hygiene, Montana State Board of Health; assistant director, Maternal and Child Health Division, U. S. Children's Bureau. *Present position:* chief, Division of Maternal and Child Health, California Department of Public Health.

Mary Schieffelin Brown (Mrs. Charles S.)—New York, N.Y.

Member, Board of Directors, Henry Street Settlement; chairman, Nursing Committee of the Henry Street Visiting Nurse Service; member, Advisory Committee to Bureau of Nursing, City Department of Health, New York, N.Y.; member, Executive Committee and Board of Directors, NOPHN; former president, Association of Junior Leagues of America; member, New York City Nursing Council for War Service; board member, American War-Community Services, representing NOPHN; second vice-president, NOPHN, for the last biennial period.

Edwin F. Daily, M.D.—Washington, D.C.

M.D. from University of Colorado School of Medicine. *Positions held:* instructor, Depart-

ment of Obstetrics and Gynecology, University of Chicago; director, Maternal and Child Health Division, U. S. Children's Bureau. *Present affiliations:* member, Subcommittee on Medical Care of Committee on Administrative Practices of American Public Health Association; member, Section Council, Maternal and Child Health Section, APHA. *Present position:* director, Division of Health Services, U. S. Children's Bureau.

Albert W. Dent—New Orleans, La.

A.B. from Morehouse College, Atlanta, Ga. *Affiliations:* member, Advisory Committee, National Association of Colored Graduate Nurses; member, Committee on Negro Program, National Tuberculosis Association; member, Commission on Services to Children in War Time, Children's Bureau; member, National Advisory Committee, United Seamen's Service; board member, New Orleans Social Hygiene Association. *Positions held:* superintendent, Flint-Goodridge Hospital of Dillard University. *Present position:* president, Dillard University, New Orleans.

Florence Miner Farr (Mrs. Walter G.)—Brookside, N.J.

Graduate of Smith College, Northampton, Mass. *Past affiliations:* member, Citizens' Advisory Committee to Village Council, South Orange, N.J.; councilman, Smith College Alumnæ; president, Smith College Club of the Oranges, N.J.; member, Public Relations Committee, SOPHN, N.J.; recording secretary and vice-president, VNA of Oranges and Maplewood, New Jersey; director, New Jersey SOPHN. *Present affiliations:* chairman, Lay Section, New Jersey SOPHN; vice-chairman, New Jersey State Rural Dental Health Committee; member, Morris County, N.J., Lay Participation Committee on Nursing; member, Joint Committee on Auxiliary Nursing Service; member, NOPHN Public Health Nursing Week Committee; member, Health Committee, New Jersey State Welfare Council; member, Morris County Health Committee, New Jersey State League of Women Voters; member, Advisory Board, Morristown, New Jersey, VNA.

Hugh R. Leavell, M.D.—Louisville, Ky.

B.S., University of Virginia; M.D., Harvard Medical School; Dr.P.H., Yale University. *Present affiliations:* professor of public health, University of Louisville, School of Medicine; member, Governing Council and Executive Board, American Public Health Association; chairman, Section on Public Health, Southern Medical Association; member, Board of Directors, Louisville Community Chest, Louisville, Ky. *Present position:* director of health, Louisville and Jefferson County Health Department, Louisville.

Helen Byrne Lippmann (Mrs. Walter)—Washington, D.C.

*Past affiliations:* Red Cross nurse's aide in France (1917-1919); secretary, Colony Club, New York City. *Present affiliation:* national director, Volunteer Nurse's Aide Corps, American National Red Cross, Washington, D.C.

Joseph W. Mountin, M.D.—Washington, D.C.

B.S. and M.D. from Marquette University, Milwaukee, Wis. *Past affiliations:* secretary and chairman, Preventive Medicine Section of Southern Medical Association; secretary, Health Officers Section of APHA; director, Local Health Work, Missouri State Health Department; special advisor, Tennessee State Health Department. *Present affiliations:* Regular Commissioned Corps, USPHS; chairman, Section on Preventive and Industrial Medicine and Public Health of American Medical Association. *Present position:* medical director, chief, States Relations Division, United States Public Health Service, Washington, D.C.

Elsie T. Rider (Mrs. Stuart W.)—Minneapolis, Minn.

B.A. from Smith College, Northampton, Mass. *Past affiliations:* president, Junior League, Minneapolis; president, Community Health Service; president, Maternity Hospital. *Present affiliations:* board member, Community Health Service, Minneapolis; board member, Maternity Hospital; 4th ward chairman, OCD Women's Activities; member, Speaker's Bureau, American Red Cross.

Rose Schneiderman—New York, N.Y.

*Past affiliations:* director, Brookwood Labor College, Katonah, N.Y.; board member, Bryn Mawr Summer School for Working Women; general organizer, International Ladies' Garment Workers Union; committee member, Central Trade and Labor Council for Establishment of N.Y.C. Labor Party. *Present affiliations:* secretary, New York State Department of Labor; president, National Women's Trade Union League; president, New York Women's Trade Union League; member, United Cloth Hat and Cap Makers' Union Local 23. *Positions held:* representative, Paris Peace Conference, representing labor conditions of American working women; delegate, First International Working Women's Congress, Washington, D.C. (1919); delegate, International Congress in Vienna (1923); member, Labor Advisory Board, National Recovery Administration.

Nathan Sinai, Dr.P.H.—Ann Arbor, Mich.

Dr.P.H., University of Michigan. *Past affiliations:* consultant, U. S. Public Health Service; member, Advisory Committee, Children's Bureau; consultant, Ontario Medical Associa-

tion; consultant, Department of Social Security, State of Washington; technical staff, Committee on the Costs of Medical Care. *Present affiliations:* U. S. Public Health Service; Children's Bureau; Ontario Medical Association; American Public Health Association; Committee on Medical Care; president-elect, Michigan Public Health Association; consultant, Associated Hospital Service, N.Y. *Positions held:* health officer, Stockton, California; research staff, Committee on Costs of Medical Care; director, Medical Economics, 20th Century Fund. *Present position:* professor of public health, University of Michigan.

Pauline M. Spaulding (Mrs. Sumner)—Beverly Hills, Calif.

Graduate of Wellesley College, Wellesley, Mass. *Past affiliations:* president, Los Angeles YWCA; president, Wellesley Club of Southern California; chairman, Family Welfare Division, Council of Social Agencies, Los Angeles; chairman, Finance Committee, Los Angeles VNA. *Present affiliations:* first vice-president, Los Angeles Council of Social Agencies; commissioner, County Housing Authority of Los Angeles; board member, Citizens' Advisory Committee on Public Welfare of Los Angeles County; board member, Southern California Council on Inter-American Affairs; chairman, Program Planning, YWCA; chairman, finance and board member, Los Angeles Association; member, Committee on Review of Program and Budget of National Board, YWCA; board member, Los Angeles American Red Cross; member, General Budget Committee, Los Angeles Community Welfare Federation.

Priscilla K. Thaxter (Mrs. Langdon T.)—Portland, Me.

*Past affiliations:* president, District Nursing Association, Portland, Me.; president, Council of Social Agencies, Portland; president and board member, Junior League, Portland; board member, Red Cross Home Service, Bath, Me.; board member, Family Welfare, Portland. *Present affiliations:* member, Advisory Committee, State Department of Health and Welfare; member, Advisory Committee, State Department of Nursing; chairman, State Social Protection Committee; member, Executive Committee, Board and Committee Members Section, NOPHN; vice-president, Portland Community and War Chest.

**Nominating Committee 1944-1946**

Zella Bryant—Chicago, Ill.

Graduate, Kentucky Baptist Hospital, Louisville, Ky.; B.S., George Peabody College, Nashville, Tenn. *Positions held:* operating room supervisor, Middleboro Hospital, Middleboro, Ky.; public health nurse (tuberculosis), Board of Tuberculosis Dispensary, Louisville, Ky.; staff nurse, Visiting Nurse Association; home nursing director and nursing consultant, Middleboro Chapter, Red Cross; assistant to director of nursing, Eastern Area, American Red Cross; assistant chief nurse, OCD. *Present position:* associate public health nursing consultant, U. S. Public Health Service.

Eula B. Butzerin—Washington, D.C.

Graduate, Presbyterian Hospital School for Nurses, Chicago, Ill.; B.S. and M.A., Teachers College, Columbia University, New York, N.Y. *Positions held:* assistant principal and instructor, School of Nursing, Christian Church Hospital, Kansas City, Mo.; health specialist, Extension Division, Kansas State Agricultural College; Army Nurse Corps serving in France; director, course in public health nursing, University of Minnesota; associate professor of nursing education, University of Chicago; educational assistant, Red Cross Home Nursing, American Red Cross, Washington, D.C.

Anne G. Dellenbaugh (Mrs. F. S.)—Litchfield, Conn.

B.S., Smith College, Northampton, Mass. *Offices held:* board member and secretary, Community Health Association, Boston; secretary and president, SOPHN, Mass.; executive committee, Massachusetts Central Health Council; Council of Social Agencies, Boston; board member, Massachusetts Society for Mental Hygiene; executive committee, Metropolitan Conference for Social Planning, Boston; executive committee, Health League, Boston; member, Executive Committee of Board and Committee Members Section, NOPHN; member of Board and Executive Committee, NOPHN; NOPHN representative, National Nursing Council for War Service; board member, Arlington, IVNA, Arlington, Va.

Laura A. Draper—Minneapolis, Minn.

Graduate, Philadelphia General Hospital; B.A., Wellesley College; B.S., Simmons College, Boston. *Positions held:* staff nurse, supervisor, Community Health Association, Boston; assistant director, Boston Community Health Association; territorial supervisor, Metropolitan Life Insurance Company; director, Minneapolis Community Health Service.

Amy Louise Fisher—Raleigh, N.C.

B.A. from Carthage College; R.N., University of Cincinnati; M.A., Teachers College, Columbia University. *Positions held:* school and community nurse, Konnarock Training School, Konnarock, Virginia; Watauga Parish nurse, Boone, N.C.; supervising nurse, Durham City and County Health Department; Watauga County

nurse, Avery-Watauga-Yancey District Health Department, Boone, N.C.; consultant in public health nursing, North Carolina State Board of Health, Raleigh, N.C.

Anna C. Gring—Montclair, N.J.

Graduate, Homeopathic Hospital, Reading, Pa.; B.S., Teachers College, Columbia University. *Positions held:* staff nurse, VNA, Reading, Pa.; public health nurse, Visiting Nurse and Child Welfare Association, Salem, N.J.; educational director, Visiting Nurse Association, Springfield, Mass.; nursing consultant, Massachusetts, Rhode Island and Vermont, American National Red Cross; assistant director, NOPHN; assistant director, Red Cross home nursing, American National Red Cross; chairman, Program Committee, SOPHN; member, Committee to Study Supervision in School Nursing; member, Records Committee, NOPHN. *Present position:* director, Bureau of Public Health Nursing, Montclair.

Marie Neuschaefer—Des Moines, Iowa

Graduate, Kings County Hospital, Brooklyn, N.Y.; B.S., Teachers College, Columbia University. *Positions held:* supervising nurse, New York Lying-In Hospital; staff nurse, Henry Street Visiting Nurse Service; staff and supervisory nurse, W. K. Kellogg Foundation, Mich. *Present position:* director, Division of Public Health Nursing, Department of Health, State of Iowa.

Lucile Perozzi—Portland, Ore.

B.A., University of Oregon; M.A., University of Chicago. *Positions held:* staff position, Portland Bureau of Health, Portland, Oreg.; educational director, Oregon State Board of Health; director, Division of Public Health Nursing, Oregon State Board of Health; public health nursing consultant, Children's Bureau, Washington, D.C.

Rosalie I. Peterson—New York, N.Y.

Graduate, University Central School, Minneapolis; B.S., University of Minnesota. *Positions held:* nursing supervisor, Minnesota State Department of Health; public health nursing consultant, U. S. Indian Service and U. S. Public Health Service, Washington, D.C.

Lydia B. Stokes (Mrs. S. Emlen)—Moorestown, N.J.

Graduate, Vassar College, Poughkeepsie, N.Y. *Offices held:* president, VNA, Moorestown, N.J.; board member, Welfare Association, Moorestown, N.J.; board member, Cinnaminson Home, Riverton, N.J.; chairman, Board and Committee Members Section, NOPHN; member, American Friends' Service Committee; Board of Governors, Cosmopolitan Club, Philadelphia, Pa.

# COME AND GET IT!

It would be interesting to know why in so many health departments and boards of education every public health nurse is required to go to the central office each month for her salary check and whether the custom was established at the desire of chiefs or staff nurses? In the 1943 NOPHN Yearly Review questions were asked about monthly pay check procedures at the request of a large school nursing department.

In only 2 municipal health departments in a sample of 93 were checks mailed routinely, whereas in 43 each nurse called each month at the central office or the city treasurer's office. Seven of the 43 were large cities. Here particularly, the large nursing staffs must have to take considerable professional time to do this errand. Among the others, 30 health departments made arrangements for the checks to be called for at local offices, 7 sent checks by messenger, 3 allowed one nurse to call at the central office and then distribute the checks, and 8 had combinations of some of these methods.

Twenty of 94 county health departments used the mail. In 14 more the nurse called at the central office for her salary check. Practices varied from county to county in the same state. Information at hand indicates that the call at the central office for the salary check was usually arranged at the time of a staff meeting or some other convenient occasion.

Among 138 boards of education employing nursing staffs, 26 sent pay checks by mail. However, 54 required that nurses call at the central office. School nurses are even more likely than health department nurses to have their offices in outlying districts of the city, and school nurse time used to call each month for checks must total many days of service. Of the remaining, 23 arranged for their nurses to call at local school offices, 9 sent the pay check to the principal of the school in which the nurse was working on pay day, 8 arranged that the check be put in the nurses' school mailboxes. The others utilized a variety of methods.

Something done in these many cities to simplify the means of giving nurses their pay checks would save many hours of professional nursing time each month.

—DOROTHY E. WIESNER
NOPHN STATISTICAL DEPARTMENT

# Proposed Revisions of NOPHN Bylaws*

At the Biennial meeting of the National Organization for Public Health Nursing in Buffalo, New York, during the second week in June, a meeting of the members will be held on June 6 at 9:30 a.m. at which time the following proposed amendments to the bylaws will be presented for adoption:

| PRESENT BYLAWS | PROPOSED REVISION |
|---|---|
| ARTICLE I | ARTICLE I |
| Membership | Membership |
| Section 1. Classes of Membership | Section 1. Classes of Membership |
| The membership of this corporation shall consist of two classes: | The membership of this corporation shall consist of two classes: |
| Class A—Individual | Class A—Individual |
| 1. *Nurse* | 1. *Nurse Members* |
| *The requirements for nurse membership shall be:* | *Any graduate nurse complying with the state law for registration of nurses may become a member.* |
| *a. Graduation from an accredited school for nurses connected with a general hospital having a daily average of 50 patients or more. Curriculum should include practical experience in caring for men, women, and children, together with theoretical and practical instruction with medical, surgical, obstetrical, and pediatric nursing.* | |
| *b. Compliance with the state law for registration of nurses in states where such laws exist.* | |
| 2. *Associate Nurse* | |
| *Graduate nurses not eligible for nurse membership may become associate nurse members.* | |
| 3. *Lay* | 2. *General Members* |
| *Non-nurse individuals may become lay members.* | *Any non-nurse individual interested in public health nursing may become a member.* |
| Class B—Agency | Class B—Agency |
| 2. Associate Agency | 2. Associate Agency |
| Organizations or other groups interested but not administratively engaged in public health nursing may become associate agency members. | Organizations or other groups interested but not administratively engaged in public health nursing may become associate agency members. |
| Applicants for nurse, *associate nurse,* agency, and associate agency membership shall submit applications to the Secretary which shall be referred to the Eligibility Committee. After approval by the Eligibility Committee, the applicant shall become a member upon payment of dues as hereinafter provided. | Applicants for nurse, agency, and associate agency membership shall submit applications to the Secretary which shall be referred to the Eligibility Committee. After approval by the Eligibility Committee the applicant shall become a member upon payment of dues as hereinafter provided. |

**Proposed revisions in italics. Comparison will show omitted words.*

Applicants for *lay* and sustaining membership shall become members upon payment of dues as hereinafter provided.

Applicants for life membership shall become members upon payment of dues and may become members upon payment of dues in part if authorized by the Board of Directors.

Section 2. Dues

1. The annual dues of *individual nurse, associate nurse, and lay members* shall be $3.

4. The annual dues of an agency member shall be an amount equal to one percent of its total expenditures for public health nursing service in its fiscal year last preceding the calendar year for which such dues are payable (*maximum dues $1,000;* minimum dues $10 if the nursing staff is less than *twenty-five* and $25 if the nursing staff is *twenty-five* or more).

ARTICLE III

Directors

Section 1. Number

The number of directors constituting the Board of Directors of the corporation shall be 31, composed of:

Class a. Ten nurse members;

Class b. Sixteen *lay* members, at least eight of whom shall be board or committee members of public health nursing services or organizations;

Class c. Five additional persons who shall be members of any class of membership. In case the number of directors shall at any time be lawfully increased, the Directors then in office, by majority vote, shall have the power to fill any vacancies in the Board of Directors arising from such increase (unless previously filled by the members) by election of additional directors, and any directors so elected shall hold office until the next regular election and until their successors shall be duly elected and qualified.

ARTICLE V

Committees

1. Executive Committee

The Executive Committee shall be composed of the President, First Vice-President, Second Vice-President, Secretary, Treasurer, and eight other members of the Board of Directors, chosen by the Board, of whom four shall be nurse members and four *lay* members.

Applicants for *general* and sustaining membership shall become members upon payment of dues as hereinafter provided.

Applicants for life membership shall become members upon payment of dues and may become members upon payment of dues in part if authorized by the Board of Directors.

Section 2. Dues

1. The annual dues of *nurse members and general members* shall be $3.

4. The annual dues of an agency member shall be an amount equal to one percent of its total expenditures for public health nursing service in its fiscal year last preceding the calendar year for which such dues are payable (minimum dues $10 if the nursing staff is less than *five* and $25 if the nursing staff is *five* or more).

ARTICLE III

Directors

Section 1. Number

Class b. Sixteen *general* members, at least eight of whom shall be Board or Committee members of public health nursing services or organizations;

ARTICLE V

Committees

1. Executive Committee

The Executive Committee shall be composed of the President, First Vice-President, Second Vice-President, Secretary, Treasurer, and eight other members of the Board of Directors, chosen by the Board, of whom four shall be nurse members and four *other* members.

The foregoing proposed amendments have been approved by the Executive Committee of the Organization.

MARION G. HOWELL, R.N., President
RUTH HOULTON, R.N., Secretary

# Reviews and Book Notes

## WAR AND CHILDREN

By Anna Freud and Dorothy T. Burlingham. 191 pp. Medical War Books, Information Center, 227 West 13th Street, New York, N. Y., 1943. $3.50.

Probably no question is asked more frequently of the person returning to this country from England at war than, "How have the children been affected?" In their book, "War and Children," Anna Freud, the daughter of Sigmund Freud, and Dorothy Burlingham, an American psychologist, have attempted an answer based upon their experiences in operating three London nurseries for the Foster Parents for War Children.

Americans were given a fictionalized, yet basically true picture of the problems of the war child in the film, "Journey for Margaret," but few of us realized that we were also shown in that film something of the success of the work in Miss Freud's Hampstead Nursery and of her deep understanding of human beings, especially small ones.

War always offers immense opportunity for research in many fields, but rarely can the best advantage be taken of this opportunity. Most people are too busy, too distracted, too tired to initiate tedious research. But here we have a report of carefully compiled data which is published while we are still in the midst of the war. It is based on case studies and observations made through intimate daily contacts with children. The presentation is simply done and, as one reads it, it is easy to imagine the many sleepless nights made noisy by the barrage fire, illuminated by searchlights, and filled with note writing, while these women sat near to their little charges ready to provide that "security" that total war destroys.

This book is not really so much a description of "War and Children" as it is an illumination of the nature and behaviour of children in any environment. War sometimes points up certain factors hitherto hidden and clarifies thought that has been hazy or unformed. This is the case in this little book. The authors constantly try to show us how closely behaviour in the Children's Centre parallels childish behaviour anywhere. They tell how Charlie, aged 4½, called from his bed that "the shelter was not safe enough, and that the house would fall down on him," in exactly the same way he would in peacetime have called to his mother that he was afraid of an earthquake or a thunderstorm. They tell also how the primitive tie between mother and baby is the basis for the development of one type of air raid anxiety that is seen when a child shakes and trembles with the anxiety of the mother. How often we have seen this happen to the child whose mother is afraid of electrical storms! The converse of this is equally true in war as in peace, when the child of a mother who is calm and fearless reflects the same qualities.

War dislocates families, bringing forth all the problems and reactions to them that are often present in whole or in part when the family is broken for more preventable causes during peace time. The section in this book devoted to reactions of the children to evacuation and foster care will give much help to those of us who work with children who have been placed with foster parents or have lost father or mother through death or divorce. All public health nurses working with children in their own homes, or with children in day care nurseries, will find

much food for thought in the following statements:

Our case material shows that it is not so much the fact of separation to which the child reacts abnormally as the form in which the separation has taken place. (page 84). . . Today the knowledge that certain types of mental maladjustment always coincide with the lack of ordinary home life in the first five years, is still restricted to a few psychiatrists and psychologists. (page 189). . . Education demands from the child continuous sacrifices. The child has to give up his primitive habits, to become clean, to lessen his aggression, to restrict his greed, to renounce his first sexual wishes. He is ready to pay this price if he gets his parents' love in return. If such love is not available, education has to threaten, or to drill or to bribe—all methods unsatisfactory in their results. Our educational success in the war nurseries, therefore, will largely depend on whether we can succeed in creating or conserving for the children, their proper emotional relationships with the outside world. (page 191)

ELISABETH COGSWELL PHILLIPS, R.N.
*New York, N. Y.*

### AIR-BORNE INFECTION

By Dwight O'Hara, M.D. 114 pp. The Commonwealth Fund, New York, 1943. $1.50.

This book should be read by all public health nurses because it gives a fairly clear picture of some of the natural processes which may influence the decline of certain diseases which enter the body by way of the upper respiratory tract. The influence which artificial immunization and some chemotherapeutic agents have had on the incidence and mortality of some air-borne infections is also discussed.

The author might well have added that chemotherapy of some infectious diseases has not only decreased the mortality but has also made it possible to treat many more individuals than was possible with serum therapy. He does mention the more economic way of finding tuberculosis by mass X-raying.

The reader will find in this small volume excellent material to serve as a basis for instruction of the general public, industrial and other specialized groups of individuals.

The present-day need for recognizing the problems which confront persons of the middle and older ages is properly presented. These problems are of no less interest to the medical and nursing professions than to persons concerned with old-age pension, unemployment insurance and other phases of social security.

A. BARKLIE COULTER, M.D.
*Washington, D.C.*

## RECENT PUBLICATIONS AND CURRENT PERIODICALS

### MATERNAL AND INFANT CARE

BIRTHS, INFANT MORTALITY, MATERNAL MORTALITY. Publication No. 288, Children's Bureau, Department of Labor. Superintendent of Documents, Washington, D. C., 1943. $1.

These charts, maps and tables, based on material released by the Bureau of the Census for the year 1940, interpret data on births and infant and maternal mortality in the United States.

STATEMENT OF ADMINISTRATIVE POLICIES—EMERGENCY MATERNITY AND INFANT CARE PROGRAM. EMIC Information Circular No. 1, superseding MCH Information Circular No. 13 and all other EMIC policy memoranda. Children's Bureau, Department of Labor, Washington, D. C. 20 pp. Free.

THE PUBLIC HEALTH NURSE AND FAMILY PLANNING. Planned Parenthood Federation of America, 501 Madison Avenue, New York 22, N. Y., 1944. 29 pp. 5c.

### RURAL NURSING

RURAL CASE WORK SERVICES. Marjorie J. Smith. Family Welfare Association of America, 122 East 22nd Street, New York 10, N. Y., 1943. 62 pp. 50c.

### EYE HEALTH

MANUAL FOR USE WITH INDUSTRIAL EYESIGHT PROTECTION APPRAISAL FORM. National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y., 1943. 8 pp. 5c.

Both form and manual will be very useful to industrial nurses.

# NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

**Tentative Program**
**NOPHN BIENNIAL BUSINESS MEETING**
**June 5-8, 1944**

Since the convention this year is to consist primarily of business meetings, the program sessions with papers and planned discussions of previous years will be omitted. However, there will be many opportunities for discussion of subjects of outstanding interest in connection with the presentation of reports by special committees. Among the many questions to be considered are:

What adjustments in public health nursing services must still continue in order to meet wartime needs?

How are public health nurses to plan for the postwar world?

How are the social and health aspects of nursing being integrated in the basic curriculum?

How can we maintain the interest in and support of the NOPHN by the national community at large?

What is the future of industrial nursing and what problems will it have to meet?

Monday, June 5
- 9:30 a.m. Group discussion on tuberculosis
  Other group discussions
- 7:30 p.m. Board of Directors

Tuesday, June 6
- 9:30 a.m. Opening business session
- 2:00 p.m. NOPHN Sections: School, Industrial, Board and Committee Members
- 4:15 p.m. Joint Board of Directors

Wednesday, June 7
- 9:30 a.m. Council of Branches
- 2:00 p.m. Council of Branches
- 4:00 p.m. Membership Committee

Thursday, June 8
- 9:30 a.m. Closing business session

## BIENNIAL NOTES

● Hotel reservations should be made directly through A. J. Morgan, Buffalo Convention Bureau, 602 Genesee Building, Buffalo, New York. And make them early! No person should leave home for Buffalo who does not have written confirmation of her reservation. Prices of single rooms without bath range from $1.65 to $2.20 per night; with bath, $1.65 to $3.85 up; double rooms without bath, $2.75 to $3.00 up; double with bath, $3.30 to $5.50 up; with twin beds, $3.30 to $6.60 up. There has been a 10 percent increase in rates since 1941.

● Due to space limitations the Magazine will not carry this year as usual information about railroad, bus and airline fares to the Biennial. Such rates can easily be secured from local ticket agents. As in the case of hotel reservations, those planning to attend should arrange for tickets and other transportation reservations as soon as possible. Also, purchase and have in your possession *before leaving home* your return trip accommodations.

● There will be an opportunity for a small group discussion on tuberculosis, Monday morning, June 5. Anyone interested in participating in such a group will please get in touch with Louise Lincoln, tuberculosis nursing consultant, NOPHN.

● Many public health nursing agencies are requesting information about new motion picture films on VNA activities and general health subjects. If you would be interested in an hour or two or three of films at the Biennial, write to NOPHN. Perhaps it can be arranged.

● The streamlining of sessions at the Biennial to include business only has not discouraged commercial exhibitors. A full roster of all your old friends among the products and some new ones will be represented in the booths of the Convention Hall. NOPHN will have a spacious reception space there where public health nurses can drop in at any hour during the meeting.

## NOPHN STAFF FIELD SCHEDULE

| *Staff Member* | *Place* | *Date* | |
|---|---|---|---|
| Mary C. Connor | Athens, Ga. | March 6-16 | |
| | Los Angeles, Calif. | April | University of California |
| Ruth Fisher | Goldsboro, N. C. | March 9-10 | Advisory service, American War-Community Services |
| | Atlanta, Ga. | March 13-15 | " |
| | Jacksonville, Fla. | March 17-18 | " |
| Ella L. Gilmore | Richmond, Ind. | March 27-28 | Survey of public health nursing |
| Heide L. Henriksen | St. Louis, Mo. | May 12-14 | Convention, American Association of Industrial Physicians and Surgeons and Industrial Nurses |
| Hortense Hilbert | Portland, Maine | March 20 | Advisory service, American War-Community Services |
| | Allentown, Pa. | April 17 | Survey of public health nursing upon invitation of city government |
| | Charleston, W. Va. | May 1 | General Session, West Virginia State Health Conference |
| Ruth Houlton | Washington, D. C. | March 17-18 | Commission on Children in Wartime, Children's Bureau |
| Mrs. Louise Lincoln | Philadelphia, Pa. | March 3 | The Henry Phipps Institute |
| | Newark, N. J. | March 7 | New Jersey Tuberculosis League, Inc. |
| | Jacksonville, Fla. | March 21 | Florida Tuberculosis and Health Association |
| | Lakeville, Mass. | April 6 | Institutes |
| | Middleton, Mass. | April 7 | |
| | Rutland, Mass. | May 2 | |
| | Westfield, Mass. | May 3 | |
| | Boston, Mass. | May 4 | |
| | Chicago, Ill. | May 10-12 | Meetings, National Tuberculosis Association |
| | Ann Arbor, Mich. | July 3-22 | Teach, summer school course in tuberculosis nursing |
| Jessie L. Stevenson | Arizona | March 6-10 | Advisory service, Crippled Children's Division and Public Health Nursing Division, State Department of Health |
| | | | District Nurses' Association |
| | Los Angeles and San Francisco, Calif. | March 15-24 | Advisory service, city, county, and state health departments, visiting nurse associations and universities |
| | | | American Physiotherapy Association —northern and southern chapters |
| | Portland, Ore. | March 27-31 | Advisory service, Division of Public Health Nursing, Crippled Children's Division, State Department of Health; Visiting Nurse Association; University of Oregon |
| | Seattle, Wash. | April 3-7 | Advisory service, Division of Public Health Nursing, Crippled Children's Division, State Department of Health; University of Washington |

| *Staff Member* | *Place* | *Date* | |
|---|---|---|---|
| | Helena, Mont. | April 10-11 | Advisory service, Division of Public Health Nursing, Crippled Children's Division, State Department of Health |
| | Alliance, Neb. | April 17 | One-day institute |
| | Lincoln, Neb. | April 18 | Advisory service, Crippled Children's Division, State Department of Health |
| | Omaha, Neb. | April 19-25 | Survey of orthopedic services and two-day institute |
| Dorothy Rusby | Washington, D.C. | March 21-23 | Conference, U. S. Office of Education |

## NOPHN HONOR ROLL

Forty-five more agencies this month join the NOPHN Honor Roll, making a total of 129 so far this year. Let's try to swell this number to 1,000 before the Biennial meetings in June. So if your agency is 100 percent enrolled, let NOPHN know as soon as possible.

**ARKANSAS**
*Hot Springs—Metropolitan Life Insurance Nursing Service

**CALIFORNIA**
Bakersfield—Kern County Health Department

**COLORADO**
*Denver—Visiting Nurse Association
*Pueblo—Metropolitan Life Insurance Nursing Service
Sterling—Board of Education

**CONNECTICUT**
*East Hartford—East Hartford Public Health Nursing Association
Torrington—Brooker Memorial Nurse
*Wallingford—Community Nursing Service of the Wallingford Tuberculosis and Relief Association

**DELAWARE**
Wilmington—Visiting Nurse Association of Wilmington

**ILLINOIS**
Carlinville—Macoupin County Sanatorium Board
Dundee—Dundee Public Health Nursing Service
Granite City—Metropolitan Life Insurance Nursing Service
Normal—Fairview Sanatorium—Outpatient Department

**IOWA**
*Marshalltown—Community Nursing Service

**KANSAS**
*Salina—Public Health Nursing Association

**KENTUCKY**
*Albany—Clinton County Health Department
*Madisonville—Metropolitan Life Insurance Nursing Service

**MASSACHUSETTS**
*Arlington—Arlington Board of Health
*Dedham—Dedham Emergency Nursing Association
*Lowell—Visiting Nurse Association of Lowell
*Richmond—Community Health Association of Richmond and West Stockbridge
Winchester—Winchester District Nursing Association

**MICHIGAN**
*Grand Rapids—Kent County Health Department

**MINNESOTA**
*Glencoe—McLeod County Public Health Association
Hinckley—Pine County Nursing Service

**MISSISSIPPI**
Holly Springs—Marshall County Health Department

**NEBRASKA**
*Gering—Demonstration District Health Unit No. 1
Omaha—Nebraska Tuberculosis Association

**NEW YORK**
*Ilion—Metropolitan Life Insurance Nursing Service
*Mineola—The Nassau and Suffolk Counties Committee on Mothers' Health Centers
*Mt. Vernon—Visiting Nurse Association
Poughkeepsie—Visiting Nurse Association

**NORTH CAROLINA**
*High Point—Metropolitan Life Insurance Nursing Service
*Raleigh—Metropolitan Life Insurance Nursing Service

**OHIO**
*Cleveland—University Public Health Nursing District
*Massillon—Public Health Nursing Department, Massillon City Hospital
Springfield—City Health Department
*Toledo—Toledo District Nurse Association

**PENNSYLVANIA**
*Philadelphia—Visiting Nurse Society, North Branch

**SOUTH DAKOTA**
Martin—Bennett County Public Health Nurse

**TENNESSEE**
Centerville—Hickman-Lewis District, Department of Public Health
*Nashville—Metropolitan Life Insurance Nursing Service

**TEXAS**
*Dallas—Dallas Public Schools, Department of School Health Work
*Fort Worth—Tarrant County Health Unit

**WISCONSIN**
Shawano—Shawano County Public Health Service

*On Honor Roll for five years or more.

# NEWS AND VIEWS

## Highlights on Wartime Nursing

### COUNCIL ENDORSED

Registration of the National Nursing Council for War Service under the President's War Relief Control Board was authorized at a meeting of the Board on March 9. The Council may indicate the action of the Board by an imprint on its letterhead and literature reading "President's War Relief Control Board Registration No. D-36." Solicitation of funds for continuance of the Council's work, from foundations and other sources previously approached may continue as before with this added and important federal endorsement.

### UNIFORMS AND INCOME TAX

Whether the purchase price of nurse uniforms and their upkeep can be deducted from gross income for income tax purposes was the subject of a hearing on February 26 before the Commissioner of Internal Revenue in Washington, D.C. The hearing was attended by representatives of NOPHN, ANA, and NLNE as well as by members of the Tax Commission and interested attorneys. Public health nurses present were Ruth Houlton, Pearl McIver, Marion W. Sheahan, and two District of Columbia nurses in uniform—one from the Instructive Visiting Nurse Society, one from the Health Department.

According to present procedure, the Bureau of Internal Revenue does not allow this deduction, even though the Tax Court of the United States in July 1943 held in certain cases that cost of purchase and laundering of uniforms is deductible. At the hearing the Commissioner of Internal Revenue gave as his reasons for non-acquiescence (1) the law is not clear in the matter (2) one hundred million dollars in taxes would be lost to the government if all workers in uniforms, including nurses, were allowed to make this deduction.

The question will now be argued before the Circuit Court. Probably no decision will come from this Court in time for deductions on the 1944 income tax but the eventual prospect looks hopeful for nurses. It was pointed out in the hearing that the cases previously taken up by the Tax Court were not public health nurses, but that arguments in favor of allowing deductions to this group are similar and perhaps even stronger than those on behalf of hospital and private duty nurses.

### JUNE NURSING CLASSES

Establishment of June classes is a recent and necessary adjustment in traditional nursing school curricula to the needs of a nation at war, according to a statement issued by the Division of Nurse Education, USPHS, March 14.

June classes offer a helpful solution to the problem of increasing the nurse power as soon as possible. The danger level of the nurse shortage is not passed. The need is still acute, and can be met only if every school of nursing adds a June class to its program this year. The goal of 65,000 new students for the fiscal year has not been met, and it appears now that it can be met only through large June enrollments.

Originally it was hoped that 48,000 students would be enrolled by January 1, 1944, leaving 17,000 to be procured for February and June classes. Instead, 28,000 must be recruited in the second half of the fiscal year, which will end June 30. While enrollment data for February classes is not yet in, there is reason to believe the figure will not be encouraging. This, of course, means that enormous emphasis must be thrown on June classes.

Normally, three-fourths of all annual admissions enter schools in fall classes. This procedure, actually, results in top-heavy schedules. With the great majority of admissions concentrated into one period, teaching and supervisory facilities of schools are taxed to the utmost for one part of the year, and utilized to less than peak capacity during the remainder of the year.

June admissions tend to even out use of the educational plant. They permit maximum utilization of limited teaching facilities by keeping each member of the teaching staff on the type of work for which she is best prepared. Establishment of large June classes means catching the girl right out of high school and right out of college. It means that schools no longer will run the three-month risk of losing prospective students. One of the more outstanding benefits to hospitals is the stabilization of nursing service which results from having June students ready for more productive practice by the time September classes leave the school.

It is recognized that some schools will experience difficulty in establishing June classes. Supervisory and instructional personnel is limited in many schools. Scarcity of housing facilities makes June admissions difficult in some areas. Lack of adequate clinical facilities often curtails expansion. These bottlenecks, however, can be overcome through careful planning. A vigorous attack on these problems must be organized at once.

It is necessary that the effort be expended on establishment of large June classes—that present deficiencies in the goal of 65,000 new student nurses for this year can be met. Only by meeting this goal—by making available nursing service at the bare level of necessity—can the patients' minimum needs be met and the nursing schools and the nursing profession meet their wartime responsibility to the nation.

## CADET PLEDGE PROGRAM

The USPHS and the National Nursing Council are joint sponsors of the new U. S. Cadet Nurse Corps pledge program. The purpose is to enroll qualified junior and senior high school girls as prospective candidates for the Corps. Good health and good scholastic standing in the junior or senior class of an accredited high school are minimum requirements for the U. S. Cadet Corps pledgees. Pledge pins and cards will be distributed to girls sending in proper credentials. "Pledging" will not guarantee their eligibility for actual entrance or obligate any school to accept them. It will, however, announce to their friends and associates that they desire to become nurses.

Responsibility for follow up of pledgees rests with state nursing council recruitment chairmen. Representatives of state or local nursing councils will be delegated to call on all pledgees, to answer questions about the Cadet Nurse Corps, to assist them in choosing schools of nursing, and stimulate continued interest in nursing. Application blanks for pledgees can be obtained from state councils for war service. Detailed information can be secured from the NNCWS, 1790 Broadway, New York City.

## COLLEGE WOMEN IN NURSING

College women form over twice as large a proportion of students now entering nursing as ten years ago, according to the NLNE report on "Educational Qualifications of Student Nurses." A study of enrollments in 1,000 schools of nursing in 1943, according to the League, shows that 13 percent of the almost 93,000 students had had some college work before beginning their nursing preparation. A study in 1932 of 70,000 student nurses revealed only 6 percent with any previous college work.

This increase of interest in nursing on the part of college students is amply substantiated by reports from field representatives of the National Nursing Council and the U. S. Cadet Nurse Corps as a result of recent visits to 570 colleges. These representatives were impressed not only by undergraduate interest but also by the interest of university and college executives in nursing programs leading to a degree. The universities and colleges are already exploring the possibilities of inaugurating nursing programs in which local hospitals and other health agencies can be used for clinical practice. The increase of this type of program and the number of students entering such schools can be safely forecast.

## SENIOR CADETS IN FEDERAL SERVICE

With passage of the federal law on March 7, to allow federal services to use senior cadets, the assignment of senior cadets for their supervised practice period will progress very rapidly. At the meeting of the Board of Directors of the National Nursing Council for War Service on March 17, 1944, in New York, it was voted to recommend to the President of the United States that the minimum rate of pay for senior cadet nurses assigned to the federal nursing services be the rate recommended by the Council of Federal Nursing Services, namely, $60 per month. Two new leaflets are available for the information of


**The first meeting of the new Committee on Recruitment of Student Nurses of the National Nursing Council for War Service was held February 24 at Council headquarters in New York City. A cooperative campaign by nurses, hospital administrators, educators, and civic leaders to meet the year's quota of 65,000 new student nurses was mapped out. Seated, left to right: Mrs. E. B. Wickenden, Mildred Riese, Edith H. Smith (Chairman), Dr. Donald Smelzer (Vice-Chairman), Lucile Petry, Mrs. Eben J. Carey. Standing: Leah Blaisdell, Lucile Reynolds, Dr. Walter C. Eells, Florence Meyers, Mary Elizabeth Lancaster, Sister Charles Marie, Katharine Faville, Mrs. Mary Anita Perez, Mildred Tuttle, M. Cordelia Cowan, Jean Henderson.**

cadets, "The Army Needs You!" and "What Every Cadet Nurse Should Know about a Senior Cadet Period in the Navy."

## COMMISSIONED RANKS FOR NURSES

Actual rank during the war and for six months thereafter is granted Navy nurses in a new federal law, in effect February 26, 1944. A bill (HR 3761) providing *permanent* commissioned rank for Army nurses is still pending. Efforts to secure passage of the Army bill are strongly supported by the American Nurses' Association, which has sent copies of the bill to all state nurses' associations with the urgent request that they obtain the interest of their congressmen without delay, in favor of the bill.

## RADIO SCRIPT AVAILABLE

Through the courtesy of the Instructive Visiting Nurse Society of Washington, D.C., and Station WTOP of the Columbia Broadcasting System, Inc., a half-hour radio script prepared by Betty Grove, a professional radio writer, has been made available to public health nursing agencies. This script dramatizes the case of a fourteen-year-old boy suffering because of friction in the home, and the part a public health nurse was able to play in helping bring him back to sound physical and mental health.

In making the script available Miss Grove wrote, "As a general rule it is WTOP's policy not to release scripts. We are making an exception in this case in the hope that the program may be of help in publicizing an extremely valuable community service. Permission has been granted by our program director for other visiting nurse associations to use the script, or to adapt it for their own use, if WTOP and the Columbia Broadcasting System are credited. In any such case or cases, we should appreciate being informed of station and broadcast date. We found it a pleasure to work with the Instructive Visiting Nurses of Washington, D.C. They were unusually helpful and cooperative."

As potential cuts are indicated on the script, it can be reduced to a fifteen-minute program if necessary. It can also be adapted for use other than on the radio.

Will all agencies who would like to have copies of this script write to Edith Wensley at the NOPHN? If enough agencies are interested and are willing to pay a slight charge, copies can be mimeographed.

● A business meeting of member schools of the Association of Collegiate Schools of Nursing will be held in Buffalo on June 9 at the time of the Biennial Meeting of the ANA, NOPHN and NLNE.

## From Far and Near

● The Twenty-fifth Anniversary Conference of the Bureau of Maternal and Child Health, New Jersey State Department of Health, will be held on May 2 at Essex House, Newark, New Jersey. Dr. W. H. Kilpatrick, Katharine Lenroot, Dr. Arnold Gesell are among the speakers on the all-day program. Alice F. Boyer, supervisor of nurses, Bureau of Maternal and Child Health, is in charge of arrangements.

● The annual meeting of the New Jersey State Organization for Public Health Nursing will be held at the Essex House, Newark, N.J., on April 28.

● Annual convention of the Washington State Organization for Public Health Nursing will be held May 5-6 at Wenatchee, Wis.

● Election of Mrs. Eleanor Brown Merrill, executive director of the National Society for the Prevention of Blindness, as president of the National Health Council for 1944 was announced on March 15. The NOPHN is one of the 20 voluntary health organizations which comprise the Council.

● Elizabeth Taylor, director, Yonkers Visiting Nurse Association, and Ruth Kahl of the Industrial Hygiene Institute, United States Public Health Service, will represent public health nursing as members of the American Public Health Association Subcommittee on Accident Prevention.

● Formation of a statewide Mental Hygiene Committee, patterned after that formed in 26 other states and tied in with the National Committee for Mental Hygiene, is being considered in Iowa by a group headed by Dr. Walter Bierring, commissioner, State Department of Health. Purposes of the Committee would be public education in mental health, understanding of Iowa's program for child and family welfare and state institutions, and assistance in preventing nervous and mental disorders and mental defects. Such a program is felt to be needed in the state to deal with war and post-war problems.

● Appointment of Professor C.-E. A. Winslow as editor of the *American Journal of Public Health*, succeeding Harry Stoll Mustard, M.D., has been announced by the American Public Health Association. He takes office with the April issue of the magazine. Professor Winslow is well known to public health nurses through his books and articles and as chairman of the NOPHN Advisory Council.

● The Los Angeles County Civil Service Commission announces "duration of war" appointments, which do not necessitate a visit to Los Angeles, in the Los Angeles County General Hospital, Olive View Sanatorium (tuberculous patients), Rancho Los Amigos (chronic patients) or other county institutions as graduate nurse. Beginning salary is $164 a month for a 48-hour week. Candidates will be rated on their training and experience as indicated by their applications, which will be received continuously throughout the year. For application blanks and further information, write to the Commission at Room 102, Hall of Records, Los Angeles 12, Calif.

***April for Cancer Control***—April was set aside as cancer control month by Congress in 1938. The campaign against cancer in this country is conducted by the Women's Field Army of the American Society for Control of Cancer of which Mrs. Harold V. Milligan is national commander. In 1944 the campaign will stress (1) education of men about cancer (previously education of women has received major attention) (2) the fact the treated-in-time cancer can be cured (3) development of cancer prevention clinics (4) inclusion of information about cancer in secondary school health programs. "Fear, delay, and ignorance," states Mrs. Milligan, "are the main stumbling blocks to the conquest of cancer. The public health nurse is in a particularly strategic position to help remove these barriers, by knowing how to recognize the early symptoms of cancer and persuading individuals with suspicious signs to seek qualified medical diagnosis and treatment without loss of time, and by reassuring these people and their families as to the hopeful outcome in store for them with proper care."

***Cancer in the United States***—Sharp increase in the number of deaths attributed to cancer in recent decades has awakened widespread interest in the disease, resulting in intensification of

efforts to discover its cause. From eighth or ninth place in rank among the leading causes of death in 1900, the disease advanced to second place in 1940, being exceeded as a cause of death only by diseases of the circulatory system.

Although there is some indication that the rate of increase of the death rate is slowing down, it is estimated that there are about 475,000 to 500,000 persons under treatment for cancer at any given time in the United States. Each year about 300,000 new cases are diagnosed for the first time, and in addition to these cases are those who have been treated and cured as well as those with an undiagnosed tumor. The number in the two latter groups is unknown.

This information about cancer is contained in a survey report "Illness from Cancer in the United States" by H. F. Dorn, U. S. Public Health Service, appearing in *Public Health Reports*, issues of January 14, 21, and 28, 1944.

Cancer attacks relatively more people in the South than in any other region of the country, according to the USPHS study. The number of new cases per 100,000 population per year is nearly 50 percent higher in the South than in the North among white males and nearly 40 percent higher among white females. The higher southern illness rate is due mainly to the large number of skin cancers in the region. The prevalence rates in the West are intermediate between those for the North and South. For the colored population the illness rates are also higher in the South than in the North

*(Continued on page A8)*

## PRACTICAL NURSES AND AUXILIARIES

For the duration of the war, policies for the use of practical nurses and auxiliary workers have been established in relation to Metropolitan Life Insurance Company Services. The new policies are stated in a communication, February 21, addressed to affiliated agencies by D. B. Armstrong, M.D., third vice-president:

I. The Use of Practical Nurses for Metropolitan Services

A rider for the use of practical nurses may be given upon request from an affiliated agency provided that the following conditions are met:

1. That the plan for the use of practical nurses have the approval of the agency's Medical Advisory Committee.

2. That the practical nurse be well selected and be a graduate of a recognized school of practical nursing or have had satisfactory experience.

3. That the agency have a carefully worked out plan for the introduction of the practical nurse and a schedule of field supervisory visits.

4. That the public health nurse continue to give care between the visits of the practical nurse and supervise the care given by the practical nurse.

5. That the practical nurse be assigned only to cases that have already been seen by the public health nurse, and to those patients who are not acutely ill.

6. That the usual fee for visits be charged whether the visit is made by a public health or a practical nurse.

7. That such riders be reviewed at the end of one year.

II. Volunteers, Including Nurses' Aides

Since the Company provides service essentially to the acutely ill and a limited service to maternity cases and chronic cases, care may be given only by the regular staff nurses, or where authorized by a contract rider, by students or practical nurses. The reason care by nurses' aides is not sanctioned is that during the acute stage of illness or the limited visits provided maternity and chronic cases, considerable teaching is required which the nurses' aides are not prepared to give.

Naturally, there is no objection to the assignment of policyholders to nurses' aides following the termination of care to our account in those organizations where cases are cared for beyond the limits of service provided by the Company.

We realize that in case of an epidemic, an emergency change in the Company policy may be needed, but for the time being at least, such change will be made only upon request from a local community where an individual report of conditions is submitted to the Home or Head Office.

III. Cost Per Visit Statement Relating to Auxiliary Workers

1. Whenever possible, the salaries paid auxiliary workers and the total visits made by them alone should be included.

2. Where nurses' aides or other auxiliary workers who are offering their service on a voluntary basis are used, the organization is permitted to estimate the replacement value of this service, including this sum plus the visits made alone in their cost per visit statement. (See pages 41 and 42 of the NOPHN pamphlet, Statistical Reporting in Public Health Nursing.)